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HEALTH MANAGEMENT ASSOCIATES

Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches

REPORT TO

THE MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

BY
SARAH BARTH
SHARON SILOW-CARROLL
ESTHER REAGAN
MARY RUSSELL
TAYLOR SIMMONS

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Health Management Associates (HMA) is a consulting and health policy research firm specializing in health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, providers, and foundations, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, HMA has offices in Albany, New York, Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Costa Mesa, California; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; Los Angeles, California; New York, New York; Philadelphia, Pennsylvania; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento, California; San Antonio, Texas; San Francisco, California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

About the Authors

Sarah Barth, JD, is a principal with HMA's New York office. She has over 25 years of experience in publicly-funded health care policy, research and management. Sarah has more than 18 years of experience in Medicaid administration, working for both New Mexico and Massachusetts to develop managed long-term service and supports programs and health care reform initiatives. Throughout her career, she has worked closely with state and federal governments, health care foundations and non-profits, health plans, consumers and providers to improve the quality and cost-effectiveness of publicly-financed health care. Areas of specialty include dual integration strategies to align Medicare and Medicaid benefits for dually eligible beneficiaries, Medicaid managed long-term services and supports programs, home and community-based service programs and health care reform.

Sharon Silow-Carroll, MBA, MSW, is a managing principal in HMA's New York office. She has more than 25 years of experience conducting health policy research and analysis, focusing on identifying and assessing innovative initiatives to enhance quality, access, efficiency, and coverage in public and private healthcare systems. Sharon specializes in qualitative research and evaluation, with recent studies focusing on value-based payment reforms, prenatal care strategies for vulnerable women, Medicaid quality measurement systems; hospital best practices for reducing readmission and infection rates; and care coordination for children with special health care needs.

Esther Regan is a senior consultant in HMA's Lansing, Michigan office. She has more than 30 years of experience in Medicaid program policy and administration, including serving as a senior advisor to the Michigan Medicaid director. Esther specializes in Medicaid policy, law, and regulation. She is an expert in the development of new policies and the evaluation of their feasibility, legality, impact, and effectiveness. Throughout her career, she has provided technical assistance to state Medicaid officials in their development of procurements to support program activities and has assisted numerous managed care organizations and other entities in responding to Medicaid solicitations.

Mary Russell, MPH, is a senior consultant in HMA's Los Angeles office. Mary specializes in developing and evaluating managed care, quality improvement and health education programs. Prior to HMA, Mary was a clinical project manager at L.A. Care Health Plan, the largest publicly operated health plan in the nation, where she implemented and evaluated quality improvement programs for the dual eligible population. This included managing cross-functional workgroups to implement the Duals Demonstration pilot and providing ongoing coordination between product and clinical operations.

Taylor Simmons, MPH, is a research assistant in HMA's Denver, Colorado office. She has experience in writing in-depth literature reviews, conducting focus groups and key informant interviews, putting together models of care, performing policy analyses, and analyzing large qualitative data sets. Taylor specializes in public health initiatives and structured project management support.

About the Funder

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

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I. EXECUTIVE SUMMARY

Care coordination is a key component of integrated, whole person care for individuals enrolled in both Medicare and Medicaid (dually eligible beneficiaries) who are served by integrated care models. Dually eligible beneficiaries are a demographically diverse population. They often have multiple health care, behavioral health, long-term services and supports and social service needs. Many face adverse social risk factors that may affect health status – social determinants of health (SDOH) – such as housing insecurity and homelessness, food insecurity, inadequate access to transportation, poverty, and low health literacy. This diversity and combination of potentially high-risk and high-cost needs underscore the importance of health plan care coordination for dually eligible beneficiaries that effectively: assesses their range of needs; incorporates those needs and individual preferences and goals in person-centered care plans; and coordinates and shares information across all needed medical and non-medical providers and supports, including family and other caregivers.

States are increasingly turning to managed care to deliver and coordinate care and supports for Medicaid beneficiaries with higher needs, including those dually eligible for Medicare. At the same time, dually eligible beneficiaries are increasingly enrolling in Medicare managed care options, and both states and the federal government are supporting models that promote communication and coordination across Medicaid and Medicare. With the continued enrollment of higher need and potentially higher cost populations into such integrated care programs, the need to understand existing care coordination standards, how they are being operationalized, and which practices appear promising to stakeholders is paramount.

This report was prepared by Health Management Associates (HMA) under contract to the Medicaid and CHIP Payment and Access Commission (MACPAC) to better understand health plan care coordination standards, practices and trends across integrated care programs. HMA reviewed health plan care coordination in the following three integrated care models for dually eligible beneficiaries: 1) Medicaid Managed Long-Term Services and Supports programs with requirements for integration with Medicare Advantage Dual Eligible Special Needs Plans (MLTSS+D-SNP); 2) Medicare Advantage Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP); and 3) capitated Financial Alignment Initiative (FAI) demonstrations. The health plans implementing these models operate under a range of state and federal contract requirements and disparate health plan practices related to care coordination.

This report synthesizes a literature review, a detailed review of contract provisions relevant to care coordination for dually eligible beneficiaries, and interviews with key stakeholders to provide insights and identify:

- Trends and unique provisions in care coordination contract requirements across models and states
- State, health plan, provider, and beneficiary experiences implementing, monitoring, or receiving care coordination services

- Promising care coordination practices and challenges for ensuring effective care coordination for dually eligible beneficiaries

Key Findings on Health Plan Care Coordination in Three Integrated Managed Care Models

In general, variation in integrated care model contract requirements was most pronounced across states (versus across models), with just a few states providing detailed specifications on particular care coordination elements. Tennessee and Virginia MLTSS+D-SNP contracts have the most detailed care coordination requirements. These states have operated managed programs for a number of years, giving them the opportunity to refine care coordination approaches. A few other states include unique or specific care coordination contract standards as well. Elements of care coordination that are more fully defined in certain contracts and reflect emerging areas of focus are: transitions of care between acute and non-acute settings; information technology, data requirements, and reporting; health risk assessment integration and information sharing; family and other caregiver involvement and assessment; and SDOH.

The degree of contract prescriptiveness on care coordination requirements has implications for both setting minimum standards and facilitating innovation. The level of prescriptiveness in the state contracts varied across the three model types and across states. Health plans generally prefer flexibility rather than prescriptive language regarding care coordination in contracts to allow for innovations. However, many stakeholders agreed that it is important for state and federal expectations regarding minimum standards to be clear. Health plan representatives acknowledge that for MLTSS+D-SNP models, Medicare plans are not always interested in coordinating care and services with a Medicaid MLTSS plan if they are not contractually required to coordinate. Specifically, they suggest dually eligible beneficiaries enrolled in companion Medicare and Medicaid plans (i.e., operated by the same parent company) have requirements around formal coordination, and those in unaligned plans (i.e., not operated by the same parent company) to have some formal coordination requirements, as in the proposed rule, Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly, Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021; Policy and Technical Changes (CMS-4185-P) (Contract Year 2020 Medicare Advantage and Part D Flexibility Proposed Rule). Even with such requirements, health plan staff need to be educated and trained on how data can be legally shared to alleviate health plan, care coordinator, and provider concerns about sharing data.

It is increasingly understood that care coordination focuses on individual client needs, goals and preferences. There is recognition across stakeholders that dually eligible beneficiaries and their families and other caregivers should be at the center of integrated program models that support their varied and often complex needs. This recognition is reflected in many Medicaid contracts with health plans serving dually eligible beneficiaries that require comprehensive assessments (including two states that require assessments of caregivers' needs), person-centered care planning and goal-setting, and communication across interdisciplinary care teams

and D-SNPs. Yet stakeholders interviewed shared federal person-centered care planning requirements[1] have been interpreted differently by states and health plans. Based on experience to date, most stakeholders agree that successful care coordination is based on building relationships, engaging members to identify their goals and preferences, and supporting and empowering members to achieve those goals.

Health plans continue to face care coordination challenges, though innovative solutions are emerging. Health plans in integrated care models face challenges in realizing the full benefits of care coordination. Some involve difficulty implementing contract requirements, while others are broader challenges serving an often high-need high-cost population and coordinating across systems with different rules and funding streams. For example:

- A variety of stakeholders identified enrolling and engaging individuals and families and other caregivers in the care planning process as a key challenge. Advocates suggest greater state and managed care organization collaboration with the disability community to understand the unique characteristics of the population and related needs and improving access to interpreters for members with limited English proficiency (LEP).
- Health plans continue to struggle to engage primary care providers (PCPs) in care coordination activities including interdisciplinary care team meetings, given that dually eligible beneficiaries enrolled in integrated models comprise a small portion of their panel. Health plans are exploring incentives and value-based arrangements to engage PCPs in care coordination and reduce the siloed approach to the work of care coordinators and PCPs.
- Relationships between care coordinators and nursing facilities can be tense, making coordination during transitions difficult. Placing health plan case managers in institutional settings to be a resource for the nursing facility and their residents is one approach to improving that relationship.
- Reducing duplication in administration of health risk assessments across Medicare and Medicaid is challenging because of differences in program requirements for collecting information.

Conclusions and Looking Ahead

While stakeholders' views varied in some areas, there was agreement that successful health plan care coordination for dually eligible beneficiaries is centered on building relationships, engaging individuals to identify their goals and preferences, and supporting and empowering them to achieve those goals using culturally and linguistically appropriate methods. Stakeholders posited that successful care coordination results in:

- High member satisfaction, with dually eligible beneficiaries knowing who their care coordinator is and how to access care coordination
- Health plans acting affirmatively to help individuals access resources, rather than individuals working to get the coordination they need and want
- Fewer adverse events and better health and quality of life outcomes

- Smooth transitions between settings of care, with a decrease in unnecessary emergency room visits and hospital readmissions
- Beneficiaries living in the least restrictive setting with needed and appropriate services and supports
- Cost efficiencies and savings resulting from more appropriate use of services

Next steps for effective care coordination include greater member engagement and technology that promotes integration. Such steps may include increasing face-to-face (versus telephonic) care coordination for dually eligible beneficiaries with more complex needs, incorporating social service needs into health risk assessments (HRAs), further defining and measuring person-centered planning and applying lessons from integrated managed care models (e.g., high-intensity care coordination) to beneficiaries not yet dually eligible, such as people with stage IV kidney disease. Suggestions include: integrating electronic medical records and sharing data; working with members to engage in their health (and using internal auditing tools to assess member understanding of trainings); and enhanced care coordinator training in end-of-life conversations to ensure members understand their rights and choices in care.

Because care coordination practices are evolving, the specificity of contract requirements may evolve as well. Expertise is growing among health plans regarding the needs of dually eligible beneficiaries and care coordination practices that best meet those needs. New and planned programs serving dually eligible beneficiaries can learn from established programs such as the capitated FAI demonstration programs, FIDE SNPs such as the Minnesota FIDE SNP program and MLTSS+D-SNP models such as Tennessee's. Evaluations of the different models of integrated care will further identify successful innovations, which could be considered when establishing standards. Stakeholders suggest that CMS can play an important role in sharing of best practices for care coordination.

There is room for further innovation and sharing of emerging practices in addressing SDOH. State contracts with health plans vary in addressing SDOH, from requiring care coordinators to identify and facilitate access to community resources, to specifically requiring that a staff person be designated as an expert on housing, education and employment resources. At the same time, health plans are learning more about the importance of addressing SDOH and are incorporating SDOH in the care coordination process and technology platforms. They are also partnering with community-based organizations that help address housing stability and homelessness, food insecurity, access to transportation and other social needs. As successful strategies for addressing SDOH through comprehensive assessments, care plans, and community partnerships are identified, they could be shared more broadly.

Additional federal guidance could help clarify new integration opportunities and address barriers. The CMS Administrator announced in December 2018 that the agency will outline new FAI-related opportunities for demonstration states and other states.[2] Health plans shared that the ideal for the MLTSS+D-SNP model would be to have dually eligible beneficiaries enrolled in companion Medicare and Medicaid plans (i.e., operated by the same parent company) with requirements around formal coordination and those in unaligned plans Medicare and Medicaid

plans (i.e., not owned by the same parent company) to have some formal coordination requirements – which is contained in the Contract Year 2020 Medicare Advantage and Part D Flexibility Proposed Rule (CMS-4185-P) which builds upon provisions of the Bipartisan Budget Act of 2018 (P.L. 115-123) to establish new required integration and coordination activities for D-SNPs.

Additional research is needed to assess differences across models and guide the design of integrated Medicare-Medicaid programs for dually eligible beneficiaries going forward. To date, there have been few comprehensive program evaluations extending beyond the initial year of the capitated FAI demonstration programs and a limited number of evaluations of FIDE SNP models (Minnesota and Massachusetts) to support a comparison of the effectiveness of care coordination across the three integrated care program models. Further research can inform the evolution of integrated care for dually eligible beneficiaries, as well as other high-risk, high-need, high-cost populations. This includes process and impact evaluations of the current and evolving models, with a particular focus on how key elements of care coordination affect outcomes under different levels of integration. Further research is needed to define appropriate measures that reflect care coordination outcomes related to improving health status and quality of life, creating person-centered plans and achieving individuals' personal goals reflected in the plan, addressing SDOH, and appropriately utilizing services and realizing related cost efficiencies.

II. INTRODUCTION

Background

As of December 2018, more than 12 million individuals nationwide were enrolled in both Medicare and Medicaid, referred to as dually eligible beneficiaries.[3] Eligibility for the federal Medicare program is typically tied to age (65 and older) or long-term disability. Eligibility for Medicaid, a joint federal-state program with eligibility rules and benefits that vary by state, is generally tied to income, and additional functional criteria for receipt of long-term services and supports.[4] Medicare is the primary payer for care for these dually eligible beneficiaries, mainly covering medical services including physician, inpatient and outpatient acute care, post-acute skilled level of care, and pharmacy benefits. Most dually eligible beneficiaries (72 percent in 2013) are eligible for full Medicaid benefits, and referred to as full benefit dually eligible beneficiaries. For this population, Medicaid wraps around Medicare benefits, covering Medicare premiums and cost-sharing as well as services not covered by Medicare, which are primarily long-term services and supports (LTSS) including nursing facility and home and community-based services (HCBS).[5] HCBS include a range of supportive services that help individuals continue living at home and in the community with as much independence as possible, such as personal care aides, home-delivered meals, adult daycare, and nonemergency medical transportation.[6]

Dually eligible beneficiaries are demographically diverse and have varied health care needs. They often have multiple medical conditions, behavioral health conditions and disabilities (cognitive and physical). Among dually eligible beneficiaries in 2013:[7]

- 30 percent had three to six limitations in activities of daily living (ADLs), and 25 percent had one or two ADL limitations
- 21 percent lived in an institution
- 61 percent were female
- 58 percent were age 65 or older
- 43 percent did not have a high school diploma
- 18 percent reported being in poor health compared to six percent of Medicare-only beneficiaries reporting the same

In addition to diverse and often complex health care needs, many dually eligible beneficiaries face social risk factors referred to as social determinants of health (SDOH) that can affect their health and wellness. SDOH among this population include food and housing insecurity (including homelessness), no or inadequate access to transportation, low health literacy and poverty.[8]

The diverse health and social needs of the dually eligible population underscore the importance of individualized coordination of care and services, including comprehensive needs assessments, and person-centered care plans that reflect individuals' needs, preferences and goals. Coordination is particularly critical given the frequency and complexity of transitions of

care between acute and non-acute settings, often when Medicare and Medicaid program service coverage shifts from one program to the other.

Today, a majority of dually eligible beneficiaries must navigate multiple sets of rules and benefits to access health care and LTSS through fragmented and uncoordinated systems. They get most of their primary and acute care medical services through Medicare fee-for-service (FFS) or a Medicare Advantage (MA) plan, while obtaining personal care services, adult day services, and other HCBS from different Medicaid health plans and providers. There is often little or no communication between providers and care coordinators. Other social services generally must be sought separately, and these needs may often go unmet. Individuals, and their families and other caregivers, may be confused about what services are available and how to access them, resulting in underutilization of some services and overutilization of others, poor health and quality of life outcomes, and higher costs.[9]

Dually eligible beneficiaries represent a disproportionally large share of spending in both the Medicare and Medicaid programs. In 2013, full benefit dually eligible beneficiaries comprised 20 percent of the Medicare population and accounted for 34 percent of Medicare spending. This population comprised 15 percent of Medicaid beneficiaries and accounted for 32 percent of Medicaid spending.[10]

Alignment is a means to better integrate services, increase quality, and promote cost efficiencies and savings for the dually eligible population. The Centers for Medicare & Medicaid Services (CMS) and states have explored and implemented several integrated models to align the two programs' benefits, administration and financing. These models include:

1) Medicaid Managed Long-Term Services and Supports (MLTSS) programs[11] with requirements for Medicare and Medicaid integration with MA Dual Eligible Special Needs Plans (D-SNPs) beyond federal minimum requirements (MLTSS+D-SNPs)[12]
2) MA Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)
3) The capitated Financial Alignment Initiative (FAI) demonstration through Medicare-Medicaid Plans (MMPs)

Table 1 describes these three models and the states in which they operate as of the date of contract review completion. In December 2018, 561,295 dually eligible beneficiaries were enrolled in FIDE SNPs and capitated FAI programs in 16 states.[13]

TABLE 1. INTEGRATED MODELS FOR BENEFICIARIES DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID

Model Type	Description	States
MLTSS + D-SNP **Medicaid managed long-term services and supports (MLTSS) with Medicare Advantage (MA) Dual Eligible Special Needs Plans (D-SNPs)**	States with Medicaid MLTSS programs with requirements for Medicare and Medicaid integration with MA D-SNPs beyond minimum federal requirements[i]	8 states: Arizona, Florida, Hawaii, New Mexico, Pennsylvania, Tennessee, Texas, Virginia
FIDE SNP **MA Fully Integrated Dual Eligible (FIDE) Special Needs Plans**	Under a CMS-approved MIPPA-compliant[ii] contract with State, a single managed care organization provides Medicare and Medicaid benefits under a capitated rate, with coordinated health and LTSS using aligned care management and specialty care network methods for high-risk beneficiaries[iii]	10 states: Arizona, California, Florida, Idaho[iv], Massachusetts[v], Minnesota, New Jersey, New York, Tennessee and Wisconsin
FAI **Capitated Financial Alignment Initiative Demonstration**	A State Medicaid agency, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care[vi], integrating the full range of acute care, behavioral health, and LTSS.	9 states:[vii] California, Illinois, Massachusetts, Michigan, New York (2 programs), Ohio, Rhode Island, South Carolina, Texas

i. Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (as amended by the Patient Protection and Affordable Care Act of 2010) requires D-SNPs to enter into contracts with individual states in which they operate, in addition to contracts with CMS. MIPPA sets minimum D-SNP and state contract requirements for Medicare and Medicaid integration.

ii. https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/Chapter-16b.pdf

iii. After completion of HMA contract reviews, Idaho amended its FIDE-SNP contract to expand the scope for the two participating plans to include Idaho Medicaid Plus, a mandatory Medicaid MLTSS program for dually eligible beneficiaries in a subset of the FIDE SNP geographic regions effective November 1, 2018.

iv. Massachusetts Senior Care Options (SCO) health plans are all FIDE SNPs. Eligible Medicaid-only beneficiaries may enroll in SCO.

v. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

vi. Virginia operated a capitated FAI program which ended December 31, 2017.

Snapshot of Federal and State Regulatory Environment for D-SNPs

- The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (as amended by the Patient Protection and Affordable Care Act of 2010) requires D-SNPs to enter into contracts with individual states in which they operate, in addition to contracts with CMS. MIPPA set minimum D-SNP and state contract requirements for Medicare and Medicaid integration. The minimum requirements do not detail care coordination standards. A number of states leverage MIPPA contracts to require integration and care coordination beyond the minimum requirements to ensure that care is appropriately coordinated for dually eligible beneficiaries. They are also requiring that health plans offer both a Medicaid MLTSS plan and D-SNP product to obtain state contracts.
- The Bipartisan Budget Act of 2018 (BBA) (Public Law 115-123) permanently authorized MA Special Needs Plans (SNPs), including D-SNPs. Prior to permanent authorization, D-SNPs were subject to annual reauthorization. The BBA additionally strengthened the authority of the CMS Medicare-Medicaid Coordination Office (MMCO) to develop rules and guidance regarding D-SNPs, including improving integration and coordination and unifying grievances and appeals across Medicare and Medicaid, and provide resources to states to support using D-SNPs as integration models.
- Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly, Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021; Policy and Technical Changes (CMS-4185-P) seeks to implement provisions of the Bipartisan Budget Act of 2019 establishing new D-SNP requirements. It proposes required integration and coordination activities, as well as integrated grievance and appeals processes for certain types of D-SNPs – those that meet the current FIDE SNP designation and plans that fall within the proposed rule's Highly Integrated Special Needs Plan (HIDE SNP) definition. As of the date of publication of this report this rule had not yet been finalized.

Care coordination standards are intended to ensure that health plans assess members' needs, create care plans, and establish communication channels to share information across providers, patients, types and levels of services, and sites of care. The goal is to ensure the individual's needs are met with the most appropriate care, at the most appropriate time, in the most appropriate setting. Data has shown that dually eligible beneficiaries who have access to a care coordinator are more satisfied with their care.[14] However, care coordination standards vary by program and across states, and are implemented differently by individual health plans.[15] **With the continued enrollment of high-need and often high-cost populations into integrated care programs, the need to understand existing care coordination standards, how they are being operationalized, and which practices appear promising to stakeholders is paramount to: 1) understanding whether existing standards are meeting their intended results; and 2) determining which standards may be replicated in other states.**

Objectives

To better understand care coordination standards and implementation of those standards across integrated programs and states, MACPAC contracted with HMA to examine relevant health plan contracts and interview key stakeholders. The objectives of this report are to:

- Detail specific state and federal managed care contract requirements related to care coordination under each of the three models
- Summarize state, health plan, provider, and beneficiary experiences implementing, monitoring, or receiving care coordination services
- Highlight effective care coordination practices and challenges for ensuring effective care coordination for dually eligible beneficiaries
- Identify differences and similarities in health care coordination practices across the three integrated models

III. METHODOLOGY

HMA used four methods to achieve the study's objectives: a literature review, contract reviews, stakeholder interviews, and synthesis of findings. *Appendix A: Methodology for Literature Review, Contract Review and Stakeholder Interviews* provides detailed descriptions of the literature review, contract review and stakeholder interview methodologies. Summary approaches follow below.

Literature Review

HMA reviewed more than 22 articles and reports containing overviews or analyses of care coordination requirements for integrated Medicare-Medicaid models serving dually eligible beneficiaries. This included a focused review of the websites of organizations that have examined or provided technical assistance to the programs under study. Results were used to help identify gaps in information and to inform the review of managed care contracts and stakeholder interviews.

Contract Reviews

HMA then reviewed 32 contracts involving integrated managed care program models in place as of August 2018 including:

1. *MLTSS+D-SNP*: 11 contracts including state contracts with health plans for the provision of MLTSS services that have requirements for Medicare and Medicaid integration with D-SNPs beyond federal minimum requirements and, if separate, state D-SNP contracts with health plans
2. *FIDE SNP*: 10 contracts including state contracts with health plans for MLTSS services, and, if separate, state FIDE SNP contracts with health plans
3. *Capitated FAI*: 11 three-way contracts among the state, MMP, and CMS

HMA collected and summarized contract provisions that are specific to care coordination for full benefit dually eligible beneficiaries, as well as general care coordination contract provisions that may have an important impact on dually eligible beneficiaries. Contract reviews for all integrated care models looked for patterns across care coordination standards and unique care provisions.

HMA conducted comprehensive contract reviews for MLTSS+D-SNP and FIDE SNP contracts with states. HMA reviewed contracts for states that had required companion Medicare and Medicaid plans (i.e., operated by the same parent company) in operation as of August 2018. For capitated FAI demonstrations, HMA conducted limited contract reviews to cover areas of interest such as care coordinator assessment and support of family and other caregivers, and social determinants of health, to supplement existing information summarized in our literature review.[16] Table 2 presents the states by contract type.

TABLE 2. SELECTED STATES BY CONTRACT TYPE

MLTSS + D-SNP (11)	FIDE SNP (10)	Capitated FAI (11)
Arizona	Arizona*	California
Arizona D-SNP	California	Illinois
Florida	Florida*	Massachusetts
Florida D-SNP	Idaho	Michigan
Hawaii	Massachusetts	New York (2)
Tennessee	Minnesota	Ohio
Tennessee D-SNP	New Jersey	Rhode Island
Texas	New York	South Carolina
Texas D-SNP	Wisconsin	Texas
Virginia	Tennessee*	Virginia
Virginia D-SNP		

** These states also have separate MLTSS contracts that were comprehensively reviewed and counted once if they appear in more than one column.*

Stakeholder Interviews

HMA conducted structured interviews with key stakeholders from October to December 2018 to gain insight into how care coordination requirements for integrated programs are designed, implemented, monitored, and experienced. Interviewees were selected based on their knowledge of care coordination requirements in integrated models, experience developing and operationalizing care coordination for dually eligible beneficiaries, and understanding of promising care coordination approaches and opportunities for improvement. The research team conducted 12 individual and group interviews with 30 individuals including:

- One federal official at CMS
- Three state Medicaid officials from two states (Tennessee and Virginia)
- Nineteen health plan executives from seven health plans and three health plan associations
- Two medical directors from two integrated health plans
- Three consumer advocates from two consumer advocacy organizations
- Two representatives from two home and community based-service (HCBS) organizations

HMA developed and used structured interview guides that elicited interviewee's perspectives on the level of prescriptiveness of care coordination requirements for integrated programs, successful and challenging aspects of operationalizing care coordination standards, promising practices and outcomes for dually eligible sub-populations, gaps in standards and how they were addressed, stakeholder engagement in development of care coordination standards, and suggestions for refining those standards.

Care Coordination Terminology

Our research found there is not one single term that is universally used to refer to care coordination**.** Some states have multiple systems or programs (e.g., case management and care management), with distinctions such as one system or activity being more clinically-oriented and focused on an episode of care, and other systems focusing on the ongoing, whole person needs of individuals. For this paper, we use the term care coordination as a general term that refers to coordinating and managing care and services across the continuum of primary, acute, behavioral health, long-term services and supports, and social services for dually eligible beneficiaries. For reference and example, we based this definition on contract provisions such as Integrated Care Management and Integrated Identification Process in the New Jersey FIDE SNP Article 10 highlighted below.[17]

New Jersey FIDE SNP Contract Integrated Care Management and Integrated Identification Process

10.10.5.A. **Integrated Care Management**. Comprehensive, person-centered, holistic, aligned Care Management services must be provided to each enrollee in order to integrate the full continuum of services available that will maximize each enrollee's health and personal independence. Care Management is a continuous process which commences upon enrollment and includes, but is not limited to: (1) assessing a Member's physical, behavioral, functional, and psychosocial needs; (2) identifying the physical health, behavioral health and long-term care services and other social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs; (3) ensuring timely access to and provision, coordination and monitoring of physical health, behavioral health, and long-term care services needed to help the Member maintain or improve his or her physical or behavioral health status or functional abilities and maximize independence; and (4) facilitating access to other social support services and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement.

10.10.5.B. **Integrated Identification Process**. The health plan is required to develop and implement a multi-faceted process through which each Member's needs are identified for the purposes of informing the development, implementation and monitoring of the Plan of Care as well as the frequency and intensity of care coordination. This process should at a minimum make use of a combination of predictive modeling software; health risk assessment tools; functional assessments; referrals from individuals, family Members and Providers; administrative claims data and other sources of information as appropriate. The identification strategy must consider the medical, behavioral health (i.e., mental health and substance use), LTSS and social needs of the Member. The health plan is not required to develop a formal stratification system with specific minimum contact levels or time frames for completion of activities as a result of this process but utilize the process to identify the optimal level of service for each Member.

Responses attributed to interviewees in this report use the terminology used by respondents during interviews for referencing care coordination, care management and/or case management. General references to and statements made by the authors of this report reference care coordination.

Review Limitations

The contract requirements studied and summarized do not capture the degree to which the standards are successfully implemented. Comparisons of care coordination implementation and impact across the three integrated models are also limited by the relatively few evaluations of programs reviewed. Further, the experiences shared in the limited number of interviews cannot be extrapolated to the experiences of all states, health plans, providers or consumers. However, the analysis and synthesis of findings from the literature review, contract review, and stakeholder interviews reveal trends, gaps, promising practices, and considerations for future direction of care coordination for dually eligible beneficiaries in integrated care models.

IV. FINDINGS

Notable Contract Standards

Reviews of contracts for all integrated care models looked for both patterns across care coordination standards and unique provisions. The reviews also examined variation in care coordination requirements across the integrated care models, and within the models across states.

In general, variation in care coordination requirements is most pronounced across states (versus across models), with a few states providing detailed specifications on particular care coordination elements. Consistent with Medicare model of care requirements, all capitated FAI MMP contracts specify that enrollees must have health risk assessments (HRAs), individual care plans (ICPs) and access to an interdisciplinary care team.[18,19] Capitated FAI care coordination standards are specifically tailored to dually eligible beneficiaries. However, the level of prescriptiveness varied by state and enrollee risk level. Of note, the New York Fully Integrated Duals Advantage (FIDA) contract had the most specific requirements regarding primary care provider (PCP) engagement in interdisciplinary care teams, which were subsequently lessened based on experience indicating PCPs' inability to attend team meetings in person.[20]

D-SNPs, which include FIDE SNPs, are similarly required to ensure enrollees have HRAs, ICPs and access to an integrated care team, and submit models of care outlining structures and processes for meeting these requirements to CMS for approval.[21] State contracts with these health plans also varied in level of specificity for care coordination.

Contract reviews similarly identified variation in care coordination standards across MLTSS+D-SNP model contracts.

States with MLTSS+D-SNP models with more detailed care coordination requirements in their D-SNP contracts had greater specifications for care coordination for dually eligible beneficiaries in their MLTSS contracts. Arizona, Tennessee and Virginia all have detailed requirements in their D-SNP and MLTSS contracts. These states are considered to have more mature MLTSS programs because they have operated MLTSS programs (which include Virginia's capitated FAI demonstration) for a number of years, giving them the opportunity to refine care coordination approaches. They also have dedicated leadership that has worked with stakeholders in the design and ongoing evolution of their programs. These states' experiences with program oversight regarding care coordination standards likely informed more detailed care coordination requirements in state Medicaid agency contracts (SMACs also known as MIPPA contracts) with D-SNPs.

The reviews revealed emerging standards for care coordination elements that are especially relevant for dually eligible beneficiaries. Notable contract requirements across the three integrated care models reflect current and emerging areas of focus for care coordination.

They include:

- Transitions of care between acute and non-acute care settings
- Information technology, data requirements, and reporting
- Health risk assessment integration and information sharing
- Family and other caregiver inclusion and assessment
- SDOH

Tennessee and Virginia stand out as having the most detailed requirements in these areas. A number of other states are referenced below for having very specific or unique provisions in one or more of these areas.

Contracts typically did not contain specific requirements for care coordinator training related to dually eligible beneficiaries, or stakeholder input on care coordination training and practices. A notable exception is Virginia's D-SNP provision stating that care coordinators must be trained on available Medicaid benefits and coordination of Medicare and Medicaid benefits and cost sharing.

Specific requirements for data sharing, notification and discharge planning for dually eligible beneficiaries' transition between acute and non-acute care settings support coordination of Medicare and Medicaid benefits. Across the three models, most contracts require care coordinator involvement in transitions between acute and non-acute settings including discharge planning to ensure needed services are in place. Requirements include notification across health plans of admission and discharge from an emergency room, inpatient, or residential and rehabilitation settings. Idaho's contract specifically references services needed to avoid readmissions. Tennessee and Virginia transition of care requirements are notable among MLTSS+D-SNP integrated care models for their specificity (Table 3).

TABLE 3. TENNESSEE AND VIRGINIA MLTSS+D-SNP TRANSITION OF CARE COORDINATION STANDARDS

STATE	REQUIREMENT
Tennessee[i]	Medicaid MLTSS plans must: • Coordinate with a member's D-SNP regarding discharge planning from any inpatient setting or observation stay when Medicaid LTSS (nursing facility or HCBS), Medicaid home health or private duty nursing, or other Medicaid services may be needed upon discharge • Receive and process a standardized electronic Daily Inpatient Admissions, Census and Discharge Report from each D-SNP in the Grand Region served • Ensure that all required notifications from the member's D-SNP of inpatient admission (both planned and unplanned from hospitals or SNFs), of observation days and any ER visits are timely and appropriately triaged

STATE	REQUIREMENT
	• Maintain daily reports to determine appropriate and timely engagement in discharge planning D-SNPs must: • Provide notification within 2 business days from "anchor date" (date of receipt of notification of upcoming or current inpatient admissions) and current or recently completed observation day or emergency department (ED) visits to a full benefit dually eligible (FBDE) member's TennCare health plan of all FBDE members' inpatient admissions, including planned and unplanned admission to the hospital or a SNF, as well as observation days and emergency department visits • Report each inpatient admission, observation day, and ED visit separately • Coordinate with a FBDE member's TennCare health plan regarding discharge planning from inpatient setting when Medicaid LTSS (nursing facility or HCBS) or Medicaid home health or private duty nursing services, may be needed upon discharge to ensure care is provided is most appropriate, cost effective and in the most integrated setting • Follow up with FBDE members and their TennCare health plan following observation days and ED visits to address member needs and coordinate Medicaid benefits, as appropriate
Virginia[ii]	Medicaid MLTSS plans must: • Have at least 1 dedicated transition care coordinator in each region (Regional Transition Care Coordinator) without a caseload, other than individuals in transition, to assist individuals with care transitions - care transitions include transitioning individuals from nursing facilities, hospitals, inpatient rehabilitation, or other institutional settings into the community, and assisting individuals who desire to remain in their community setting • For dually eligible Members, the Regional Transition Coordinator must also work with the D-SNP Care Coordinator upon approval of the Member, to ensure safe and effective transitions between levels of care • Establish tracking mechanisms to ensure that staff are timely and appropriately engaged in discharge planning, and for CCC Plus Members, that Care Coordinators are notified/engaged as appropriate • Maintain daily reports for audit to determine appropriate and timely engagement in discharge planning • Coordinate with a Member's D-SNP or MA Plan or other primary health plan regarding CCC Plus program services that may be needed by the Member D-SNPs must: • Provide the Medicaid plan with timely (within 48 hours of becoming aware, either through a claim submission or other means, of hospital,

STATE	REQUIREMENT
	emergency department and nursing facility admissions and discharges and within 72 hours of the diagnoses of, or significant change in the treatment of, a chronic illness) inpatient hospital, emergency department and nursing facility admissions and discharges and the diagnosis of, or significant change in the treatment of, a chronic illness in order to facilitate the coordination of benefits and cost sharing between D-SNP and Medicaid plan • Coordinate with the Medicaid MLTSS plan regarding discharge planning

i. Division of TennCare, Statewide Contract with Amendment 7 – January 1, 2018.
ii. Department of Medical Assistance Services, 2018 – DSNP – V02.

All capitated FAI demonstrations programs require coordination when the individual transitions across settings, although the language differs across contracts. Rhode Island's MMP contract is the most detailed on defining the various types of transitions across care settings (e.g., nursing facility to community, community to hospital) and in setting standards for transitional care management for MMPs. (See Text Box 1).

Text Box 1: Rhode Island Medicare-Medicaid Plans (MMP) Requirements

Rhode Island has detailed requirements related to transitions across care settings. MMPs must:

- ✓ Adopt or modify existing transition models or develop its own transition model to ensure effective transitions and continuity of care when enrollees move between levels of care.
- ✓ Have transitional care management and support during transitions across care settings twenty-four (24) hours a day, seven (7) days a week.
- ✓ Provide onsite visits with the Lead Care Manager (LCM) and/or care coordinator upon discharge from hospitals, nursing facilities, or other institutional settings.
- ✓ Modify the ICP, if necessary, within five (5) days after a hospitalization.
- ✓ Modify the Wellness Plan, if necessary, within five (5) Days of a hospitalization.
- ✓ LCM or Care Manager holds in-person or telephonic interdisciplinary care team meeting(s) on an as needed basis, including any time a dually eligible beneficiary experiences a significant change in condition.

Note: A Wellness Plan is defined as a long-term care plan, informed by the Wellness Assessment, developed to help enrollees residing in nursing facilities stay healthy in the nursing facility setting. The Wellness Plan will coordinate with all other clinical plans of care at the nursing facility and will supplement where necessary.

Certain contracts across the three integrated care models stand out in specifying data collection and information technology (IT) systems that support care coordination and related reporting requirements. Massachusetts requires health plans to have a single, centralized enrollee record that contains the individual's medical, functional and social status,

including involvement with community agencies and contacts with family members and caregivers. Idaho, Florida, Minnesota and Tennessee require annual or quarterly submission of reports to the state Medicaid agency related to care coordination.

Tennessee's MLTSS contract[22] contains the most extensive requirements related to health plan information system data sharing with D-SNPs for care coordination for dually eligible beneficiaries. (See Text Box 2).

Text Box 2: Tennessee MLTSS IT Requirements

Tennessee's MLTSS contract contained numerous requirements related to health plan information systems data sharing with D-SNPs for care coordination for dually eligible beneficiaries. The MLTSS plan must:

- ✓ Accept Medicare enrollment data and load the data in the plan's case management system for use by Care/Support Coordinators and case management, Disease Management/Population Health and Utilization Management staff.
- ✓ Be structured to facilitate the coordination of Medicaid and Medicare services in an integrated way.
- ✓ Support coordination with a member's D-SNP regarding discharge planning from any inpatient setting or observation stay when Medicaid LTSS (nursing facility or HCBS), Medicaid home health or private duty nursing, or other Medicaid services may be needed upon discharge.
- ✓ Receive and process a standardized electronic Daily Inpatient Admissions, Census and Discharge Report from each D-SNP in the Grand Region served.
- ✓ Ensure that all required notifications from the individual's D-SNP of inpatient admission (both planned and unplanned to hospitals and skilled nursing facilities), of observation days and any emergency room visits are timely and appropriately triaged.
- ✓ Maintain daily reports to determine appropriate and timely engagement in discharge planning.

Virginia requires that MLTSS plans submit policies and procedures for their electronic system and other tools care coordinators will use to integrate care for members, including integrating Medicare services for dually eligible beneficiaries. Virginia D-SNPs must submit all information requested on the "DSNP Dashboard" each month.[23] (See Text Box 3).

Text Box 3: Virginia D-SNP Monthly Dashboard Reporting Requirements

Monthly D-SNP dashboard submissions include data for the six following areas:

- ✓ Enrollment (totals for snapshot of three months)
- ✓ Enrollment demographics (plan alignment, age, residence, behavioral health)
- ✓ HRAs and Plans of Care (POC) (number of HRAs or POCs completed within 30, 60, 90, 90+ days and corresponding percentages of the total number of enrollees)
- ✓ Coordination with Medicaid Plan
  - HRAs: Medicaid plan participation, documentation provided to Medicaid plan
  - Trainings: D-SNP requested to attend and participated
  - Discharge planning: number completed, number coordinated with Medicaid Plan
  - POC: Medicaid plan participation, documentation provided to Medicaid plan
  - ED visits: number of unaligned ED visits, number of unaligned ED visits info sent to Medicaid plan
  - Hospital discharges: number of unaligned inpatient hospital discharges, number of unaligned inpatient hospital discharge info sent to Medicaid plan
  - Chronic illness: number of unaligned with chronic illness, number of unaligned with chronic illness info sent to Medicaid plan
- ✓ Grievances and appeals (number of new, closed, active, and reason for appeal or grievance)
- ✓ Staffing (number of care coordinator full-time equivalents working for VA D-SNP, ratio of enrollees to care coordinators)

Requirements to integrate Medicare and Medicaid assessments and care plans to support care coordination in MLTSS+D-SNP models. For individuals enrolled in unaligned Medicare and Medicaid plans (i.e., not operated by the same parent company) Virginia requires D-SNPs to request a representative from the enrollee's Medicaid plan to participate in all needs assessments, person-centered planning, and interdisciplinary care team meetings, and must provide the Medicaid plan with the results of the assessments. For dually eligible beneficiaries receiving LTSS who are enrolled in companion Medicare and Medicaid plans (i.e., operated by the same parent company), Tennessee D-SNPs must integrate the Medicare Health Risk Assessment and plan of care with the Medicaid Comprehensive Needs Assessment and Person-Centered Support Plan.

Three FIDE SNP programs support using an integrated Medicare and Medicaid Health Risk Assessment. Florida requires an integrated Medicare and Medicaid risk assessment upon enrollment and annually thereafter. Idaho requires a comprehensive health risk assessment be performed for each new enrollee within 20 to 90 days depending upon risk stratification level and annual reassessment thereafter. Idaho further specifies that the health plan use a standardized, person-centered and state-approved instrument that includes the member's: current health status and treatment needs; social, employment, and transportation needs; personal goals; and informal support networks.

Many contracts across models refer to including family and other caregivers in care coordination but the level of detail and expressed goals vary. Four states' MLTSS contracts require efforts to involve family and other caregivers in care coordination and two specifically noted supporting family and other caregivers' needs. A basic tenet of care coordination in Arizona MLTSS is to ensure involvement of the individual and the individual's family in making informed decisions, identifying the individual's strengths and needs, and developing the service plan. Arizona care coordinators must allow the individual's family or representative to identify their role in interacting with the service system. Minnesota specifies that MLTSS plans must have a strategy to involve individuals and family members or guardians in treatment planning and care planning, as well as provide caregiver supports and help facilitate caregiver respite. For individuals in defined subgroups of beneficiaries, Tennessee requires at least annual caregiver assessments to review family member and caregiver ability to provide caregiving services by assessing their physical and behavioral health, willingness to provide services, training needs, and any other supports needed.

All capitated FAI demonstration programs require involving the individual's family or caregiver in care coordination, "as appropriate or in accordance with the enrollee's needs or preferences."

Notably, a large number of contracts specify SDOH-related services as part of the health plan care coordination process. Contracts across integrated care models reference SDOH in the care coordination process but vary in detail and prescriptiveness.

MLTSS examples include the following:[24]

- Arizona requires care coordinators to facilitate access to non-covered services available in the community, assist members to identify their independent living goals, and provide them with information about local resources that may help them transition to greater self-sufficiency in areas of housing, education and employment. A staff person must be designated as the expert on housing, education and employment issues and resources in the service area.
- Florida MLTSS care coordinators must be trained on local resources for housing, education and employment services or programs that can help individuals gain greater self-sufficiency. There also must be a staff person designated as the expert on housing, education and employment issues and resources in the service area.
- Texas MLTSS care coordination and related specialized services include coordination of plan services with social and other services delivered outside of the plan as necessary. The plan may include information for services outside the scope of covered benefits, such as how to access affordable housing.
- Virginia MLTSS care coordination includes annual reporting in specified areas. (See Text Box 4.)

Text Box 4: Virginia MLTSS Care Coordination and Programs to Address SDOH

Virginia MLTSS health plan care coordination must identify SDOH and address member access to education, housing services, job training, food security, transportation needs, and resources that support member connection to social supports. MLTSS health plans are required to establish programs or establish partnerships to address SDOH, and report annually on four specific areas: (1) Economic Stability; (2) Education; (3) Social and Community; and (4) Health and Health Care.

A number of FIDE SNP models' care coordination standards extend to services related to SDOH, social supports and community services including housing, transportation, income assistance, and food security. They include:

- Idaho care coordinators are responsible for coordinating health plan services with the services the individual receives from community and social support providers. Health home providers must provide information on available community and social support services that aid in promoting healthy behaviors and reducing physical and mental health risk factors.
- Massachusetts care coordinators must arrange, coordinate and authorize the provision of appropriate social support services. Health plans must implement a system that coordinates care and creates linkages with organizations not providing covered services, such as social service agencies, federal agencies, and consumer, civic and religious organizations.
- Wisconsin social service coordinators are required to be part of the interdisciplinary team and are responsible for conducting assessments. The HRA is to include an exploration around the member's housing and finances, and preferences for educational and vocational activities, including supported employment.

Capitated FAI demonstration programs often include SDOH as required domains of the HRA. Most capitated FAI demonstration MMP contracts require care coordination to include assistance with accessing transportation, housing, and other supports. Massachusetts' contract is most explicit in housing and home environment factors that must be included in the HRA. (See Text Box 5).

Text Box 5: Massachusetts Capitated FAI Housing and Home Environmental HRA Factors

- Considerations specific to individuals experiencing homelessness
- Risk of homelessness
- Home accessibility requirements
- Housing preferences, including who the individual lives with
- Methods for heating and cooling enrollee's home
- Home safety
- Any services provided in a residential setting

APPENDIX B: Contract Review Findings further details specific state and federal managed care contract requirements related to care coordination including those related to care coordinator qualifications, caseload ratios, health risk assessments, person-centered care plans and interdisciplinary care teams. Of note, Appendix B reflects that some states require different care coordinator qualifications based upon stratification of individuals into different tiers for care coordination and care coordinator caseload ratio variability across states and subpopulations.

Stakeholder Perspectives and Experiences

Interviews with representatives from health plans (executives and medical directors), federal and state government, consumer advocacy groups, and HCBS organizations about care coordination in integrated care models found common themes, with some notable differences in perspectives. A majority of the findings summarized below are pertinent to all three integrated care models. It is noted when a finding is applicable to a specific model.

In general, stakeholders agree that care coordination in integrated care models must be person-centered, although this is difficult to measure and monitor. Flexibility in care coordination requirements encourages innovation and lets health plans address varied needs and circumstances, but some standardization and clear expectations are needed and considered helpful by health plans. Improvements are needed in: care coordinator training; communication and coordination between MLTSS and D-SNP plans, and among health plan care coordinators, nursing facilities and HCBS providers; engaging PCPs in care coordination and interdisciplinary care teams; and addressing SDOH. Using new technologies, some states and health plans are testing care coordination strategies to address challenges. Stakeholders shared best practices should be disseminated.

General care coordination challenges and concerns

Care coordination is dependent upon being able to locate and effectively engage dually eligible beneficiaries, according to multiple stakeholders. A consumer advocate noted that health plans often receive contact information that is outdated, inaccurate or missing, requiring plans to spend a lot of resources to find and engage individuals. An HCBS provider described partnering with a health plan, deploying community health workers to help locate members the health plan was unable to reach. One health plan representative reported using innovative approaches to "activate" members, such as using motivational interviewing techniques to

identify issues the member wants to focus on and using the patient activation measure (PAM) tool semi-annually to assess member engagement.

Health plan representatives reported that person-centered care planning requirements for care coordination have been interpreted differently by states and health plans and compliance is difficult to measure. A health plan interviewee cited a challenge with states interpreting "person-centered[25]" in different ways, with different forms and documentation requirements. Multiple health plans noted that states and CMS are not aligned in care plan requirements - for Medicare, the care plan must document all goals identified during the assessment process, but some members may not want to work on those goals; health plans would like to see a balance. See Text Box 6 for Tennessee's efforts to ensure that health plans provide person-centered care coordination.

Text Box 6: Tennessee Medicaid's Efforts to Ensure Health Plan Person-Centered Care Coordination

Readiness Reviews: During the state readiness review for its new 2018 FIDE SNP plan, via video conference Tennessee required the plan to walk through several individual member case scenarios to demonstrate how its care coordination processes would function to address physical, behavioral, LTSS and social support needs. The state made suggestions for improvement, primarily relating to addressing SDOH. The plan showed it had incorporated learnings from the state's input during follow-up walk throughs. During the same health plan's most recent readiness review for their FIDE SNP for individuals with intellectual and developmental disabilities they met all of the state's expectations for care coordination approaches.

Peer Training: Tennessee Medicaid is working with all TennCare plans, in partnership with the state Tennessee Council on Developmental Disabilities, to construct a "people planning together initiative." Health plan members will be trained to teach peers on how to better lead and guide their own person-centered planning process and drive the development of their care plans to reflect who they are and what matters to them.

CMS has begun to review plans of care to assess the degree to which they are goal-based, individualized, and understandable. A consumer advocate supported this effort and CMS' sharing model care plans to promote "best practices" but noted that there is work to be done to ensure health plans actively engage members in their care planning process and resulting care plan.

Consumer advocates are concerned that health plans operating integrated models are not sufficiently collaborating with consumers and the disability community to design and implement person-centered care coordination. Consumers are concerned about the availability of interpreters beyond Spanish and lack of engagement with family and other caregivers. A consumer advocate in one state noted that consumers have not been involved in the training of care coordinators, and collaboration with the disability community has declined since the start of the integrated care program.

Health plans generally prefer flexibility rather than prescriptive language regarding care coordination in contracts to allow for innovations. However, a state official noted it is important for expectations to be clear. All of the health plans interviewed noted that it is important to allow health plans to have flexibility to develop the model that will work best in a specific market and focus on identified program goals. However, one health plan representative suggested that the state should set expectations for meeting reporting requirements, and another acknowledged that some standardization of terms and definitions around "high-risk beneficiaries" or "level 1" would help with care coordination when dually eligible beneficiaries change enrollment in health plans.

One state Medicaid official shared that prescriptive language in health plan contracts was initially perceived as a burden to health plans but over time the health plans appreciated having clear expectations. The state works with health plans to allow flexibility and innovation where they can while still assuring accountability.

Finding the right balance of prescriptiveness in contracts is a challenge for government, according to stakeholders. One noted that states tend to be more prescriptive as they learn from experience, but government runs the risk of impeding innovation if it dictates too much.

Medicaid MLTSS and D-SNP plan coordination

There is variation between Medicaid MLTSS and Medicare D-SNP plans in care coordination practices and the importance they place on coordinating across programs. A health plan representative shared that D-SNP care coordinators are often unfamiliar with Medicaid and why they should engage with the member's Medicaid plan, suggesting the importance of educating care coordination staff about coordination across companion Medicare and Medicaid plans (i.e., operated by the same parent company), as well as unaligned Medicare and Medicaid plans (i.e., not operated by the same parent company). One health plan noted that Medicare plans are not always interested in coordinating care and services with a Medicaid MLTSS plan if they are not contractually required to do so.

A state Medicaid official shared that it is critical to have local health plan leadership who understand the value of collaboration and coordination across MLTSS plans and D-SNPs. They noted while the state provides a platform and establishes contacts for MLTSS plans and D-SNPs to share information, some health plans refused, citing privacy and data security concerns. According to the official, it is uncommon for MLTSS plans to request a representative from an unaligned D-SNP to participate in HRAs and companion Medicare and Medicaid plans are more effective with integrated care teams than unaligned Medicare and Medicaid health plans.

For MLTSS+D-SNP models, a health plan representative stated that the ideal would be to have dually eligible beneficiaries enrolled in companion Medicare and Medicaid plans with requirements around care coordination and those in unaligned Medicare and Medicaid plans (i.e., not owned by the same parent company) to have some prescribed coordination

requirements. Multiple health plans noted that for dually eligible beneficiaries enrolled in unaligned Medicare and Medicaid plans, care coordination requirements vary by state and have been minimal.

Care coordinator training

Health plan care coordinator training is not usually dictated in health plan contracts and differs by plan. It generally consists of initial foundational care coordinator training on benefits and services including Medicare and Medicaid benefits and resources, followed by more targeted training specific to the dually eligible beneficiary population's characteristics and needs. Most health plans interviewed reported that training on benefits and services is standardized. One health plan highlighted that it is essential to educate care managers and care teams on both Medicare and Medicaid benefits, and on coordinating benefits to navigate both programs within the confines of each program's requirements. Training includes scenario-based learning, whereby staff create care plans based upon member scenarios and goals provided. Another health plan relayed that ad hoc training is added as circumstances arise. A number of health plans provide ongoing training that includes updates on state and federal requirements.

One FIDE SNP representative noted that in addition to providing foundational training, they work with the state, which identifies emerging issues and convenes FIDE SNPs to address them. For example, the state and health plans together focused on reducing unnecessary arrests by law enforcement and worked with local law enforcement to create crisis plans that police could use to mitigate behavior and avoid arrests. A public official in a different state described how the state conducts semiweekly training sessions for health plan care coordinators, partnering with other stakeholders who share their expertise. Many stakeholders agreed that effective care coordinator training focuses on skills and issues targeted to the population served. Noted key training components are: patient-centeredness focusing on the "dignity of risk"[26] (from the independent living and disability rights movement framework), trauma-informed care (e.g., ask for consent and re-consent), role-playing (slowing down, thinking about how people learn, and finding words that resonate with them), counseling and motivational interviewing, and interdisciplinary care team training to more easily communicate in clinical settings. A health plan medical director observed a positive shift in training care coordinators from "checking boxes" on prescriptive requirements to a broader focus on the Triple Aim.[27] Topics include active listening, emergency room diversion, transition care planning, skilled-nursing facility diversion, end-of-life care and choices, and SDOH and related resources. Virginia's two weekly

Text Box 7: Virginia Medicaid's MLTSS Care Coordinator Training

Virginia conducts two weekly telephonic training sessions directly with MLTSS health plan care coordinators. To support open discussion, care coordinators do not have to disclose who they are when they ask questions during the session. Call agendas, presentations and frequently asked questions are sent to an extensive care coordinator email list. The semiweekly sessions are:

- Tuesday Q&A – 150 call-in lines that are full every week.
- Thursday structured calls focusing on specific conditions, populations or processes that average 300 participants per call.

telephonic training sessions with MLTSS health plan care coordinators address their questions and provide information on specific topics and populations. (See Text Box 7).

Stakeholders noted that there are opportunities for improvement in care coordinator training. States and health plans shared they are learning from prior care coordination experience in integrated care programs. Consumer advocates noted that care coordinator training needs to involve collaboration with individuals with disabilities and focus on person-centered care planning that directly engages and solicits the preferences and goals of dually eligible beneficiaries.

For the capitated FAI demonstrations, contracts purposefully did not prescribe training curriculums for care coordinators, which may have contributed to innovative training content in some states. Capitated FAI MMP contract language allowed for health plan flexibility in designing care coordination training curriculums to address the unique needs of dually eligible subpopulations. A federal official noted how various states added training content such as addressing sexual health and gender identity (Massachusetts), homelessness (Michigan), and palliative and end of life care (South Carolina). CMS sponsored webinars and more general training content, often collaborating with advocacy groups, for continuing education credits. California received an Administration for Community Living grant supporting dementia training for care coordinators.

Health risk assessment trends and issues

Few states specify the HRA tool that plans must use. A federal official pointed out that many states require HRAs to capture certain types of information, but few states specify the tool that must be used. One of these exceptions is Pennsylvania, which requires use of the InterRAI.

There is value in conducting HRAs in-person for subpopulations with complex needs. To identify unmet needs for some individuals, conducting an in-person assessment via a home visit may be more important than the tool used. One state Medicaid official noted that for specific subpopulations there is growing recognition of the value of sitting down with individuals in their homes and conducting HRAs in-person rather than just over the phone. It was also noted not all people need in-person assessments.

Having two different assessments and care plans seem duplicative and burdensome; but different Medicare and Medicaid requirements make a common assessment challenging, although there are efforts underway to address. One health plan representative noted that Medicare requires that care plans document *all* goals identified in the assessment process. The health plan is working on adopting a common assessment tool for their companion Medicare and Medicaid plans (i.e., operated by the same parent company).

Care coordinator/provider communication and engagement

There was agreement among stakeholders interviewed that engaging primary care providers (PCPs) in care coordination activities, including interdisciplinary care team meetings, is challenging. Often, dually eligible beneficiaries enrolled in one of the three integrated care

models represent only a small number of individuals on PCPs' patient panels. Small panels make it difficult to incentivize PCPs to engage with health plans. PCPs are busy and, generally, are not reimbursed for their time spent on care coordination activities. Health plans with larger market volume are in better positions to obtain meetings with PCPs and place coordinators in acute care facilities to engage in discharge planning and care transitions.

One health plan cited provider difficulty adopting technology designed to provide them information and connect them with care coordinators and interdisciplinary care teams. The health plan relayed that on-line provider portals are seen as one more tool to sign into and suggested that a standard provider portal framework across health plans might improve utilization.

Multiple interviewees including states, health plans and consumer advocacy groups stated that as a result of these challenges, PCPs and care coordinators often continue to operate in siloes without much engagement. As an exception, one state official observed successful engagement with PCPs who see the value of working with an interdisciplinary care teams and care coordinators for individuals with more complex needs. Health plans are implementing strategies to improve and incentivize PCP engagement. (See Text Box 8).

Text Box 8: Health Plan Strategies to Improve and Incentivize PCP Engagement

Health plans described strategies to improve and incentivize engagement of PCPs in care coordination, including:

- ✓ Sending the care plan to the PCP through a variety of means – health plan provider portal, fax, telephone
- ✓ Bringing a case manager into the provider's office once a week to discuss all members served by that office to reduce the time burden on provider
- ✓ Building in pay-for-performance or value-based purchasing to pay PCPs for extra time spent on care coordination
- ✓ Providing information to PCPs that are most important to them (e.g., pharmacy utilization, change in patient condition)

An HCBS provider reported that HCBS staff have not been connected to health plan care coordination activities or consumers' PCPs even though they are in consumers' homes and have developed strong and trusting relationships with consumers. According to the HCBS provider, PCPs and health plans do not consider them as part of the care team and do not share HRAs (other than the functional limitations index[28]) even though HCBS staff see the home environment firsthand and can identify changes in circumstances and condition. They noted that although there have been some small pilots to promote communication between health plans and HCBS staff, there are opportunities for greater collaboration and information-sharing to improve care coordination and reaching health plan member goals.

Nursing facility and care coordinator relationships can be challenging and vary across plans resulting in access and coordination issues, according to health plans and consumer advocates. Some health plans have no coordination with nursing facilities and some nursing facilities are reportedly hostile to health plans coming into their businesses. There are health plans that have undertaken innovative approaches to establishing care coordination relationships with nursing facilities. They include training care coordinators or case managers who can be placed in institutional settings to form relationships and be a resource to the host facility (e.g., helping to assess whether an individual can return to the community with supports, or to arrange transportation).

While interdisciplinary care team composition varies, the teams are most often led by the care coordinator who is responsible for communicating with PCPs, even if the PCPs do not actively participate. All interviewees shared that PCP participation in the interdisciplinary care team is not high. Health plan representatives said the ideal is to ask members who they want on their interdisciplinary care team, in addition to meeting contractual team composition requirements. A federal official noted that flexibility in interdisciplinary care team composition and communication is necessary to promote provider participation. This lesson was learned from the highly prescriptive interdisciplinary care team requirements in the New York capitated FAI demonstration program, FIDA, which were deemed burdensome by PCPs.

Health plans interviewed described different approaches to the interdisciplinary team, including:

- The care coordinator facilitates the interdisciplinary care team meeting across the team and ensures the right people are available to attend or follows up with those who cannot attend. The plan offers a call-in number, webinar or Skype to maximize participation.
- The interdisciplinary care team is led by the medical director and care coordinator. Care coordinators prepare an agenda using a template with drop down menu in advance, which is shared with the medical director for review and sign-off. Some members participate, and the PCP and other providers (e.g., MLTSS, behavioral health, pharmacy) are invited, although PCP participation is low.

Transitions of Care

Most stakeholder groups reported a concerted focus on transitions of care between acute and non-acute settings in all three integrated care models, consistent with results of the contract reviews. State officials interviewed said they require notification of emergency room and inpatient hospital stays across providers - hospital, medical and care coordinators. One state requires MLTSS health plans to have at least one transition coordinator per geographic region who supports discharges from nursing facilities for individuals with complex needs and who are difficult to place in community settings. Health plans are placing care coordinators and discharge coordinators in hospitals serving large numbers of their members.

One state noted that hospital discharge plan goals should be more person-centered and related to the reason for the hospital admission. A consumer advocate stated that care coordination is most critical in transitions of care across settings and requires person-centered, culturally appropriate language.

Information Technology

All stakeholder groups highlighted the importance of technology in supporting care coordination, particularly for identifying changes in condition and facilitating transitions between acute and non-acute care settings. States are requiring that health plans have technology and data capabilities to generate real-time notifications of emergency room utilization and hospital inpatient stays. Health plans are adopting more sophisticated care management platforms that enable coordination of medical, behavioral health and LTSS, as well as SDOH. Health plan partnerships with hospitals to share health records (e.g., Health Information Exchange in New York) enable notifications on member admissions and transitions. Technology with a centralized consent form allows sharing of personal health information (PHI) across settings, with member ability to change permissions at any time. (See Text Box 9).

Text Box 9: Health Plans: Using Technology to Support Person-Centered Care Coordination and Transitions between Care Settings

Health plans shared that they are using information technology to support person-centered care planning and transitions between acute and non-acute care settings including:

- ✓ Implementing a new care management platform with modules that feed information into and support customization of care plans. For example, if an individual is experiencing homelessness, there is a module built in to provide steps to address homelessness. The new platform converts the care plan into a "member point of view" document that the member can relate to and empowers the member to act on their own behalf.
- ✓ Using data from the state mandated system to provide real-time hospitalization data to help ensure the interdisciplinary care team is engaged to plan for discharge and shares diversionary strategies to avoid emergency department use.
- ✓ Establishing its own performance dashboard across all its Medicaid MLTSS and Medicare-Medicaid programs that include care coordination satisfaction, quality of life and other measures across products and across states to identify why certain results or occurrences happen in certain markets.
- ✓ Using its financial analytics department to create predictive models based on claims data to prioritize members for interventions and more intensive support. The department posts monthly reports. Additionally, each member has a report card updated monthly that automatically generates tasks for the care coordinator (e.g., flu shot needed).

One state Medicaid official reported that the state is getting better at leveraging technology to support care coordination and has a tool that provides data to patient-centered medical homes (PCMHs) and behavioral health providers. The state would like to extend the tool to all parts of

the care continuum (e.g., LTSS providers) and improve linkages between Medicare and Medicaid providers. It leveraged the D-SNP state Medicaid agency contract requirements to get D-SNPs to share data and information, but data sharing is still challenging.

Social Determinants of Health

Most stakeholders interviewed agree that health plans are learning more about the importance of addressing SDOH and are incorporating SDOH in the care coordination process. Health plans have evolved HRAs and care coordination activities to identify and address SDOH needs including housing and food insecurity and access to transportation. (See Text Box 10). One plan's electronic HRA has a robust line of SDOH questions, and SDOH needs are automatically populated in the care plan and generate referrals to resources.

Interviewees noted that states vary as to which SDOH they identify as a priority, with many prioritizing housing and transportation. States also vary in the degree they work with health plans to communicate across state agencies responsible for certain SDOH and community-based organizations (CBOs).

Text Box 10: Tennessee – TennCare Plan Care Coordinators Addressing SDOH: An Example

One TennCare plan dually eligible beneficiary member had not been to her PCP for well over a year. Initially, the plan could not locate her. A community supports worker found her living with her dog in a small shed behind someone's house, with no electricity or running water. The woman had no interest in talking to the community supports worker about her health. The worker asked her what they could help with and the woman said she was worried that it was getting colder, and she needed pellets for her stove to stay warm and her dog needed food. The worker was able to arrange having a load of wood pellets delivered every week from a manufacturing company just down the road that produced them as byproduct of its business and obtained food and dog food from a local food pantry. The woman was incredibly grateful and asked the community supports worker what she could do in turn. The worker asked her to go see a doctor and connected her with a provider who helped close gaps in preventive care and found she had a shoulder injury that prevented her from chopping wood. After receiving care for her shoulder, she was able to get wood to keep her and her dog warm. That was five years ago.

Housing: Interviewees shared states, CMS and health plans are focused on coordinating housing assistance, as well as tailoring approaches along the care coordination continuum (HRA, person-centered care planning and interdisciplinary care team activities, including transitions of care between acute and non-acute care settings) for individuals experiencing homelessness. Some states require integrated plans to have housing specialists in the state. One health plan relayed it not only focuses on helping members obtain permanent housing, but also recognizes that some individuals experiencing homelessness do not want to immediately change their housing situation. The health plan supports these individuals without stable housing in the community. Another health plan reported holding housing workshops for individuals with unstable or no housing.

Transportation: A consumer advocate stressed that transportation is critical for getting to health care appointments, picking up prescriptions, and meeting individual's nonmedical needs to stay healthy. They noted access to transportation, particularly nonemergency medical transportation (NEMT), has been challenging and has worked somewhat better when the health plan operates NEMT rather than when states use NEMT brokers. One health plan interviewed has its own transportation fleet which it says makes access to transportation much quicker for members. A health plan medical director described an integrated care plan pilot with an emergency medical services (EMS) company, whereby an emergency medical technician joins individuals in the hospital who are flagged as having high needs (typically dually eligible beneficiaries under age 65) to review medications and instructions with the nurse, take the patient to the pharmacy and home, and help them to reconcile medications and schedule follow-ups.

A consumer advocate relayed that the capitated FAI demonstrations brought both behavioral health and SDOH to health plans' attention, but that care coordinators need more training on available support resources, including contracted services and non-contracted services such as Meals on Wheels and legal services.

V. CONCLUSION

The diverse needs and often high costs of serving dually eligible beneficiaries underscore the need for programs that coordinate primary, acute, behavioral health, LTSS, and SDOH-related services and focus on individual's preferences. States are increasingly turning to managed care to deliver and coordinate care and support for Medicaid beneficiaries with higher needs, including those dually eligible for Medicare. Dually eligible beneficiaries are increasingly enrolling in Medicare managed care options, with nearly a third of full benefit dually eligible individuals in Medicare Advantage in 2017.[29]

Current integrated models, including MLTSS+D-SNP, FIDE SNPs, and capitated FAI demonstration programs, are operating under a range of care coordination contract requirements and disparate health plan practices. This synthesis of this study's literature review, examination of care coordination contract provisions relevant to dually eligible beneficiaries, and interviews with key stakeholders provides insights and implications for states, health plans, and the federal government. Key takeaways include the following.

- **Contract variation and highlights.** Variation in integrated care plan contract requirements was most pronounced across states (versus across models), with just a few states providing detailed specifications on particular care coordination elements. Tennessee and Virginia, which have more mature programs and have had the opportunity to refine care coordination approaches, have the most detailed care coordination requirements. A few other states include unique or specific care coordination contract standards as well.
- **Emerging areas of focus**. Elements of care coordination that are more defined in certain contracts and reflect emerging areas of focus are: transitions of care between acute and non-acute settings; information technology, data requirements, and reporting; HRA integration and information sharing; family and other caregiver involvement and assessment; and SDOH.
- **Contract prescriptiveness**. The degree of contract prescriptiveness on care coordination requirements has implications for both setting minimum standards and facilitating innovation. Health plans generally prefer flexibility to allow for innovation and tailoring practices to specific populations and environments. However, many stakeholders agreed that it is important for state and federal expectations regarding minimum standards to be clear.
- **Person-centered indicators of successful coordination**. While stakeholders' views about care coordination varied in some areas, they agreed that successful care coordination reflects a person-centered approach. Indicators of success include: individuals knowing their care coordinator; helping people achieve the goals that matter to them; high member satisfaction; use of culturally competent and person-centered language; smooth care transitions across settings without gaps in care; fewer adverse events and readmissions; excellent health outcomes; living in the least restrictive setting; identifying and addressing resource gaps; and realizing cost efficiencies and savings.

- **Challenges.** Health plans continue to face care coordination challenges. They struggle with engaging PCPs in care coordination activities such as interdisciplinary care team meetings, given that dually eligible beneficiaries may comprise a small portion of a PCP's panel. Other challenges include enrolling and engaging individuals and their families and other caregivers; tense relationships between care coordinators and nursing facilities; and duplication and lack of understanding and communication among Medicaid and Medicare health plans and care coordinators. For example, Medicaid and Medicare have separate assessments due to differences in program requirements for collecting information.

Looking Ahead

The findings from this study indicate that solutions to the challenges of coordinating care for dually eligible beneficiaries are emerging, but there is more to be done.

Next steps for effective care coordination include greater member and PCP engagement and technology that promotes integration. Health plans report innovative approaches that address challenges and promote integration such as:

- Increasing face-to-face (versus telephonic) care coordination for dually eligible beneficiaries with more complex needs
- Incorporating SDOH and how to address them into HRAs and personal care plans
- Integrating electronic medical records and sharing data
- Working with individuals to engage in their health
- Using internal auditing tools to assess care coordinator understanding of trainings, and enhanced care coordinator training in end-of-life conversations to ensure individuals understand their rights and choices in care
- Exploring incentives and value-based arrangements to engage PCPs in care coordination
- Placing health plan care coordinators in institutional settings to improve relationships with these providers and be a resource for them and the individuals they serve

Consumer advocates suggest greater collaboration with the disability community to understand the unique characteristics of the population and related needs and improving access to interpreters for members with limited English proficiency (LEP). Some stakeholders also suggest further defining and measuring person-centered planning and applying lessons from integrated care models (e.g., high-intensity care coordination) to beneficiaries not yet dually eligible, such as people with stage IV kidney disease.

Because care coordination practices are evolving, the specificity of contract requirements may evolve as well. Expertise is growing among health plans regarding the needs of dually eligible beneficiaries and care coordination practices that best meet those needs. New and planned programs can learn from established programs such as the capitated FAI demonstration programs and Minnesota FIDE SNP and Tennessee MLTSS+D-SNP model. Stakeholders suggest that CMS can play an important role in sharing of best practices for care coordination to inform care coordination standards.

It is increasingly understood that care coordination focuses on individual client needs, goals and preferences. There is recognition across stakeholders that dually eligible beneficiaries and their families and other caregivers should be at the center of integrated program models. This is reflected in many health plan contracts requiring comprehensive assessments, person-centered care planning and goal-setting, and communication across interdisciplinary care teams and D-SNPs. Yet stakeholders interviewed shared federal person-centered care planning requirements[30] have been interpreted differently by states and health plans. Going forward, most stakeholders agree that successful care coordination is based on building relationships, engaging members to identify their goals and preferences, and supporting and empowering members to achieve those goals.

There is room for further innovation and sharing of emerging practices in SDOH. State contracts with health plans vary in addressing SDOH, from requiring care coordinators to identify and facilitate access to community resources, to specifically requiring that a staff person be designated as an expert on housing, education and employment resources. At the same time, health plans are learning more about the importance of addressing SDOH and are incorporating SDOH in the care coordination process and technology platforms. They are also partnering with community-based organizations that help address housing stability and homelessness, food insecurity, access to transportation and other social needs. As successful strategies for addressing SDOH through comprehensive assessments, care plans, and community partnerships are identified, they could be shared more broadly.

Additional federal guidance could help clarify new integration opportunities and address some barriers. The CMS Administrator announced in December 2018 that the agency will outline new FAI-related opportunities for demonstration states and other states.[31] Health plans shared that the ideal for the MLTSS+D-SNP model would be to have dually eligible beneficiaries enrolled in companion Medicare and Medicaid plans (i.e., operated by the same parent company) with requirements around formal coordination and those in unaligned plans to have some formal coordination requirements – which is contained in the Contract Year 2020 Medicare Advantage and Part D Flexibility Proposed Rule (CMS-4185-P), building on provisions of the Bipartisan Budget Act of 2018 (P.L. 115-123) to establish new required integration and coordination activities for D-SNPs.

Additional research is needed to guide the design of integrated Medicare-Medicaid programs for dually eligible beneficiaries and other high-risk, high-cost populations going forward. Further research can inform the evolution of integrated care for dually eligible beneficiaries, as well as other complex populations. In addition to process and impact evaluations of the current and evolving models, further research is needed to define appropriate measures that reflect care coordination outcomes related to improving health status and quality of life, creating person-centered care plans and achieving individuals' personal goals reflected in the plan, addressing SDOH, and appropriately utilizing services and realizing related cost efficiencies.

The ability to compare care coordination processes and effectiveness across integrated care models will depend on program evaluations focused on care coordination. To date, there have

been few comprehensive program evaluations extending beyond the initial year of the capitated FAIs and a limited number of evaluations of FIDE SNP models (Minnesota and Massachusetts) to support a comparison of care coordination across the three integrated managed care program models. Evaluations can further identify successful innovations, which could be considered when establishing standards.

VI. ENDNOTES

[1] "Services: Requirements and Limits Applicable to Specific Services," Title 42 *Code of Federal* Regulations, Pt. 441. Sec. 301. 2016 ed.

[2] Seema Verma. *Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare*. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. SMDL #18-102. (Baltimore: CMS, 2018). https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf

[3] Ibid.

[4] For more information about Medicaid eligibility categories, see Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment Access Commission (MACPAC). *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid.* (Washington D.C.: MedPAC and MACPAC, 2018). https://www.macpac.gov/wp-content/uploads/2017/01/Jan18_MedPAC_MACPAC_DualsDataBook.pdf

[5] Conversely, "partial-benefit" dually eligible beneficiaries are eligible under mandatory Medicaid eligibility pathways referred to as Medicare Savings Programs (MSPs) and qualify for Medicaid assistance limited to payment of Medicare premiums and in some cases, Medicare cost sharing. (Source: MedPAC and MACPAC, *Beneficiaries Dually Eligible for Medicare and Medicaid*.)

[6] HCBS are optional Medicaid benefits and vary by state.

[7] MedPAC and MACPAC, *Beneficiaries Dually Eligible for Medicare and Medicaid*

[8] Melony E. Sorbero et al. *Addressing Social Determinants of Health Needs of Dually Enrolled Beneficiaries in Medicare Advantage Plans: Findings from Interviews and Case Studies.* (Santa Monica, California: RAND Corporation, 2018). https://aspe.hhs.gov/system/files/pdf/259896/MAStudy_Phase2_RR2634-final.pdf

[9] Medicaid and CHIP Payment Access Commission (MACPAC). *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare.* (Washington D.C.: MACPAC, 2018). https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare-1.pdf

[10] MedPAC and MACPAC, *Beneficiaries Dually Eligible for Medicare and Medicaid*

[11] Medicaid MLTSS refers to the delivery of long-term services and supports through capitated Medicaid managed care programs.

[12] D-SNPs are Medicare Advantage managed care plans that enroll dually eligible beneficiaries and must contract with the state Medicaid agency to coordinate Medicare benefits with Medicaid but are not required to fully integrate Medicare and Medicaid funding or administration.

[13] Health Management Associates, based on data from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *SNP Comprehensive Report*. (Baltimore: CMS, 2018). https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2018-12.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending

[14] Carrie Graham, Pi-Ju Liu, and Steve Kaye. *Evaluation of Cal MediConnect Key Findings from a Survey with Beneficiaries.* (Long Beach, CA: The SCAN Foundation, 2016). http://www.thescanfoundation.org/sites/default/files/uc_duals_phonesurvey_2016.pdf

[15] MACPAC, *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare*

[16] Joshua M. Weiner et al., *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative*, (Waltham, MA: RTI International, 2017), https://innovation.cms.gov/Files/reports/fai-carecoordination-issuebrief.pdf

[17] State of New Jersey, Department of Human Services, Division of Medical Assistance & Health Services (DMAHS). *Medicare Dual Subset-Zero Cost-Sharing Dual-Eligible Special Needs Plan (D-SNP) Comprehensive Risk Contract, Article 10, July 2017.* (Trenton, NJ: DMAHS, 2018). https://www.state.nj.us/humanservices/dmahs/info/d-snp_contract.pdf

[18] Weiner et al., *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans*

[19] Interdisciplinary care teams are an important component of integrated care programs for dually eligible beneficiaries. They typically consist of the enrollee, providers, other support professionals, and family members and caregivers. These teams work collaboratively to develop and implement care plans to meet individuals' medical, behavioral, long-term services and supports, and social service needs. (Source: Phillip, M. Soper. *Interdisciplinary Care Teams for Medicare-Medicaid Enrollees: Considerations for States.* (Hamilton, NJ: Center for Health Care Strategies, 2016). *https://www.chcs.org/media/INSIDE_ICTs_for_Medicare-Medicaid_Enrollees-012216.pdf)*

[20] Weiner et al., *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans*

[21] "SNP Approval and Model of Care Review Process", NCQA, accessed 2019. https://snpmoc.ncqa.org/

[22] State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Division of TennCare. *Statewide Contract with Amendment 7 – January 1, 2018.* (Nashville, TN: TennCare, 2018).

[23] Commonwealth of Virginia, Department of Medical Assistance Services (DMAS). *2018 – DSNP – V02.* (Richmond, VA: DMAS, 2018).

[24] DMAS, *2018 – DSNP – V02*

[25] The Affordable Care Act mandates "person-centered" delivery of LTSS, an approach to care planning which recognizes that beneficiaries are not merely passive recipients of medical care, but the individuals who can best determine what it means to be well and what is needed to achieve wellness. Person-centered planning recognizes that the person receiving services is the primary expert in his or her own goals and needs. (Source: "Person Centered Care Planning", Justice in Aging, accessed 2019, http://www.justiceinaging.org/resources-for-advocates/mltss-in-managed-care-toolkit/person-centered-care-planning/)

[26] Dignity of risk is the concept that the right to take reasonable risks and self-determination are necessary for self-esteem and dignity and should not be impeded by overly-cautious caregivers.

[27] The Institute for Health Improvement (IHI) introduced the concept of the Triple Aim, a framework that the Centers for Medicare & Medicaid Services (CMS) adopted for many years to help optimize healthcare systems by improving patient care (including quality and satisfaction), reducing healthcare costs, and improving population health.

[28] There are health plan protocols regarding critical incident reporting about specific events within 12 hours. The event is typically a fall, but there is no standardization as to what qualifies as a critical incident.

[29] CMS Medicare-Medicaid Coordination Office. *Managed Care Enrollment Trends among Dually Eligible and Medicare-only Beneficiaries, 2006 through 2017*. (Baltimore: CMS Medicare-Medicaid Coordination Office, 2018). https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/ManagedCareEnrollmentTrendsDataBrief2006-2017.pdf

[30] "Services: Requirements and Limits Applicable to Specific Services," Title 42 *Code of Federal* Regulations, Pt. 441. Sec. 301. 2016 ed.

[31] Verma*, Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare*

Appendix A: Methodology for Literature Review, Contract Review and Stakeholder Interview

In consultation with MACPAC, HMA conducted a literature review, contract review, and stakeholder interviews to identify current care coordination requirements for three managed integrated models; uncover how these standards are operationalized by health plans; and gain insights based on stakeholders' experiences into what standards may result in promising care coordination practices for dually eligible individuals. The methodologies used for each activity are outlined below.

Literature Review Methodology

The focus of the literature review was to identify and synthesize overviews and analysis of requirements for care coordination for dually eligible individuals served by Medicaid managed long-term services and supports (MLTSS) integrated with Medicare Advantage Dual Eligible Special Needs Plans (MLTSS+D-SNPs) "companion Medicare and Medicaid plans" (i.e., operated by the same parent company); Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs); and capitated financial alignment initiative (FAI) programs.

Review steps included using the search phrases (see Figure A) using multiple strategies including searching PubMed and Google Scholar for literature published going back at least five years, with a focused review of the websites of organizations known to have examined or provided technical assistance to the programs under study. Such organizations included the Integrated Care Resource Center; the CMS Medicare-Medicaid Coordination Office; the Medicare Payment Advisory Commission; Kaiser Family Foundation; the SCAN Foundation; the Commonwealth Fund; the Center for Health Care Strategies; Mathematica Policy Research; and RTI International.

FIGURE A. SEARCH PHRASES FOR LITERATURE REVIEW

- Interdisciplinary Teams in combination with Medicare And Medicaid Integration
- Financial Alignment Initiative Demonstration
- Medicare Advantage Dual Eligible Special Needs Plan
- Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan
- Managed Long-Term Services and Supports Programs
- Care Coordination
- Service Coordination
- Care Management
- Case Management
- Health Assessment
- Individualized Care Plan
- Care Transitions

In total, 22 articles were identified for the literature review and were studied for information relevant to one of the following areas of interest:

- State and/or federal standard for care coordination
- Health plan approach to meeting and operationalizing prescribed standards

- Challenges to the development and implementation of care coordination standards
- Best practices for the development and implementation of care coordination standards
- State and federal oversight of health plan care coordination activities and their "effectiveness"
- Approaches to obtaining stakeholder input and feedback on care coordination standards

Results were used to help inform the review of managed care contracts and stakeholder interviews.

Contract Review Methodology

Criteria for selection of states for contract reviews were the following:

1. *MLTSS+D-SNP*: States with Medicaid MLTSS programs with requirements for Medicare and Medicaid integration with D-SNPs beyond federal minimum requirements.[1] Some selected states have more established MLTSS+D-SNP integrated managed care models while others are more recently in place but have established goals related to MLTSS+D-SNP coordination of services for dually eligible beneficiaries.
2. *FIDE SNP:* All states' contracts relative to FIDE SNPs operating as of August 2018.
3. *Capitated FAIs*: All states that have operated a Capitated FAI.

From the above selection criteria, HMA reviewed 32 contracts in place as of August 2018 for selected states' integrated managed care program models (see full list in Table 1):

4. *MLTSS+D-SNP*: 11 contracts which include state contracts with health plans for the provision of MLTSS services and, if separate, state D-SNP contracts with health plans.
5. *FIDE SNP*: 10 contracts which include state contracts with health plans for MLTSS services, and, if separate, state D-SNP FIDE SNP contracts with health plan(s).

[1] CMS has issued guidelines and regulations for these three integrated managed care models, including the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (as amended by the Patient Protection and Affordable Care Act of 2010) that requires D-SNPs to enter into contracts with individual states in which they operate, in addition to contracts with CMS. MIPPA sets minimum D-SNP and state contract requirements for Medicare and Medicaid integration. MIPPA contracts must document each entity's roles and responsibilities with regard to dual eligible individuals and contain, at a minimum, the following eight elements (42 CFR 422.108(c)): 1. The MA organization's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits; 2. The category or categories of eligibility for dual eligible beneficiaries to be enrolled under the SNP, including the targeting of specific subsets; 3. The Medicaid benefits covered under the SNP; 4. The cost-sharing protections covered under the SNP; 5. The identification and sharing of information on Medicaid provider participation; 6. The verification process of an enrollee's eligibility for both Medicare and Medicaid; 7. The service area covered under the SNP; and 8. The contracting period. These minimum requirements do not detail care coordination standards. A number of states are leveraging MIPPA contracts to require integration and care coordination beyond the minimum requirements to ensure that care is appropriately coordinated for dually eligible beneficiaries. https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/StateResourceCenter.htm

6. *Capitated FAI*: 11 Medicare-Medicaid Plan (MMP) contracts.

TABLE 1. SELECTED STATES BY CONTRACT TYPE

MLTSS + D-SNP (11)	FIDE SNP (10)	Capitated FAI (11)
Arizona	Arizona*	California
Arizona D-SNP	California	Illinois
Florida	Florida*	Massachusetts
Florida D-SNP	Idaho	Michigan
Hawaii	Massachusetts	New York (2)
Tennessee	Minnesota	Ohio
Tennessee D-SNP	New Jersey[2]	Rhode Island
Texas	New York	South Carolina
Texas D-SNP	Wisconsin	Texas
Virginia	Tennessee*	Virginia
Virginia D-SNP		

** These states also have separate MLTSS contracts that were comprehensively reviewed and counted once if appear in more than one column.*

Once the state contracts were identified, HMA systematically reviewed the contracts for each of the three models for care coordination provisions. HMA conducted full contract reviews for MLTSS+D-SNP and FIDE SNP contracts with states. For capitated FAI MMP contracts, HMA conducted limited contract reviews to cover areas of interest such as care coordinator assessment and support of family and other caregivers, and social determinants of health, to supplement information in the issue brief *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative*.[3]

HMA conducted a full review of the New York FIDA for IDD and Rhode Island capitated FAI demonstration MMP contracts between the state, CMS and health plans. Staff conducted quality reviews for each contract through searching for key terms to ensure no provisions were missed. A separate staff member reviewed multiple contracts *(Tennessee MLTSS; Tennessee D-SNP; Virginia MLTSS; Virginia MLTSS; and others)* as an additional quality assurance check. See Table 2 for a detailed list of contracts reviewed.

TABLE 2. LIST OF CONTRACTS REVIEWED

State	***Contract Name***	***Contract Date***
Capitated FAI Contracts*		
California	California Demonstration Three-Way Contract	January 2018
Illinois	Illinois Demonstration Three-Way Contract	August 2016
Massachusetts	Massachusetts Demonstration Three-Way Contract *Addendum to Contract*	December 2015 *June 2016*

[2] New Jersey's Medicaid MLTSS contract is amended to include FIDE SNP requirements for MLTSS health plans that are FIDE SNPs.

[3] Joshua M. Weiner et al., *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative*, (Waltham, MA: RTI International, 2017), https://innovation.cms.gov/Files/reports/fai-carecoordination-issuebrief.pdf

State	*Contract Name*	*Contract Date*
Michigan	Michigan Demonstration Three-Way Contract	January 2018
New York (1)	New York Demonstration Three-Way Contract	January 2018
New York (2)	New York Demonstration Three-Way Contract with FIDA-IDD (Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities) Plan	January 2016
Ohio	Ohio Demonstration Three-Way Contract	October 2017
Rhode Island	Rhode Island Demonstration Three-Way Contract	January 2018
South Carolina	South Carolina Demonstration Three-Way Contract	November 2017
Texas	Texas Demonstration Three-Way Contract	August 2017
Virginia	Virginia Demonstration Three-Way Contract	May 2017
FIDE SNP Contracts		
Arizona	Medicare Advantage D-SNP Health Plan Agreement Between Arizona Health Care Const Containment System (AHCCCS) and UnitedHealthcare Community Plan d/b/a UnitedHealthcare Dual Complete	January 2018
California	Standard Agreement: SCAN Health Plan and Department of Health Care Services	January 2008
Florida	Agency for Health Care Administration (AHCA) Contract No. FP050 Standard Contract *Amendments 1,2,3,4*	January 2015 *January 2018*
Idaho	Medicare Medicaid Coordinated Plan (FIDE SNP)	July 2014
Massachusetts	MassHealth Senior Care Options Contract for Senior Care Organizations	January 2016
Minnesota	Minnesota Department of Human Services Contract for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) Services	January 2018
New Jersey	Medicare Dual Subset-Zero Cost-Sharing Dual-Eligible Special Needs Plan (D-SNP) Comprehensive Risk Contract, Article 10, July 2017	July 2017
New York	Medicaid Advantage Plus (MAP) Model Contract	January 2012
Tennessee	Amendment #9 of Contract between the State of Tennessee, Department of Finance and Administration, Division of Tenncare and UnitedHealthcare Plan of the River Valley, Inc.	January 2014
Wisconsin	Contract for Family Care Partnership Program between the Wisconsin Department of Health Services, Division of Medicaid Services and MCO	January 2018
MLTSS + D-SNP Contracts		
Arizona MLTSS	Arizona Long Term Care System (ALTCS) Elderly and Physically Disabled (EPD) 2017 AZ D-SNP - ALTCS EPD Contract Amendment Number 2 YH18-0001	October 2017
Arizona D-SNP	Medicare Advantage D-SNP Health Plan Agreement between AHCCS and ONECare by Care1st Health Plan Arizona, Inc.	January 2018
Florida MLTSS	Statewide Medicaid Managed Care Program, composed of the Managed Medical Assistance (MMA) Program, the Long-Term Care (LTC) Managed Care Program, and the Specialty Plan Program	Spring 2018
Florida D-SNP	Medicare Advantage Dual Eligible Special Needs Plan Standard Contract	January 2018
Hawaii (single contract)	QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals	January 2014
Minnesota (single contract)	Minnesota Department of Human Services Contract for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) Services	January 2018
Tennessee MLTSS	TennCare CHOICES and Employment and Community First (ECF)	January 2018

State	*Contract Name*	*Contract Date*
	CHOICES Statewide Contract with Amendment 7	
Tennessee D-SNP	Contract between the State of Tennessee, Department of Finance and Administration, Division of Tenncare and AMERIGROUP Tennessee, Inc.	January 2014
Texas MLTSS	Texas Health and Human Services Commission, General Contract Terms and Conditions [with additions from July 23, 2018 RFP]	January 2016
Texas D-SNP	Agreement between Health and Human Services Commission and Medicare Advantage Dual Eligible Special Needs Plan	January 2016
Virginia MLTSS	Commonwealth Coordinated Care Plus MCO Contract for Managed Long Term Services and Supports	January 2018
Virginia D-SNP	Agreement between the Commonwealth of Virginia Department of Medical Assistance Services and Plan, 2018 – DSNP – V02	January 2018
Wisconsin (single contract)	Contract for Family Care and PACE between the Wisconsin Department of Health Services, Division of Medicaid Services and MCO	January 2018

**All capitated FAI contracts are between the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services; the state Medicaid agency; and the healthcare entity, hence "three-way".*

Stakeholder Interview Methodology

HMA obtained input from an array of stakeholders that included health plans, state Medicaid officials, a federal official, consumer organizations, chief medical officers from integrated managed care plans, and home and community- provider organizations. Stakeholders were selected using the following criteria:

1) In-depth knowledge of health plan care coordination requirements in integrated managed care models serving dually eligible dually eligible beneficiaries and experience with how plans have operationalized and carried out requirements;
2) Experience developing and operationalizing care coordination for dually eligible beneficiaries that supports person-centered, integrated Medicare and Medicaid health care and LTSS, including HCBS, including transitions between different settings of care; and
3) Knowledge of promising care coordination approaches and where there may be gaps and opportunities for improvement.

In total, 12 individual and group interviews were conducted with 30 individuals, all of which are listed below in Table 2.

TABLE 2. LIST OF STAKEHOLDER INTERVIEWEES

Name, Title	*Organization*
Federal Official	
Senior Official	Centers for Medicare and Medicaid (CMS)
States	
Patti Killingsworth, *Chief of Long-Term Services and Assistant Commissioner, TennCare Bureau, Department of Finance and Administration*	Tennessee State Medicaid and DD Agency
Karen Kimsey, *Chief Deputy, Complex Care and Services, Virginia Department of Medical Assistance Services* Tammy Driscoll, *Senior Program Advisory, Complex Care and Services, Virginia Department of Medical Assistance Services*	Virginia State Medicaid Agency
Health Plans	
Michael Monson, *Senior Vice President of Medicaid and*	Centene

Name, Title	*Organization*
Complex Care	
Julie Ghurtskaia, *Senior Director of Medical Management Complex Products*	Centene
Laura Chaise, *Vice President of LTSS and Medicare-Medicaid Plans*	Centene
Maureen Pero, *Vice President of Business Development*	Aetna (Ohio)
Tony Solem, *CEO*	Aetna (Ohio)
G. Lawrence Atkins, *Executive Director*	MLTSS Association
Tom Lutzow, *President and CEO*	Independent Care Health Plan (iCare) (WI)
Lisa Holden, *Vice President of Accountable Care*	Independent Care Health Plan (iCare) (WI)
Bill Jensen, *Vice President of Marketing and Business Development*	Independent Care Health Plan (iCare) (WI)
Allision Rizer, *Vice President of Policy and Strategy*	UnitedHealth Group
Karen Evans, *Director of Clinical Operations*	UnitedHealthcare Community and State
Cheryl Phillips, *President and CEO*	Special Needs Plan (SNP) Alliance
Carol Smolij, *Director of Special Needs Plan*	Horizon Blue Cross Blue Shield of NJ
Laura Black, *Senior Vice President of Care Partnership and Service Delivery*	Commonwealth Care Alliance
John Johnson, *Chief Medical Officer*	Virginia Premier Health Plan
Dana Lawson, *Associate Vice President*	Virginia Premier Health Plan
Jennifer Seiden, *Associate Vice President*	Virginia Premier Health Plan
Margaret A. Murray, *CEO*	Association for Community Affiliated Plans (ACAP)
Christine Aguilar Lynch, *Vice President for Medicare and MLTSS Policy*	Association for Community Affiliated Plans (ACAP)
Primary Care Provider Associations/Managed Care Organization Chief Medical Officers	
Dr. Karim Lopez, *Vice President, Medical Director for Ohio*	CareSource (OH)
Dr. Toyin Ajayi, *Chief Health Officer*	Cityblock (NY)
Consumer Organizations	
Dennis Heaphy, *Chair One Implementation Council, Senior Policy Analyst*	Disability Policy Consortium
Amber Christ, *Senior Staff Attorney* Georgia Burke, *Directing Attorney*	Justice in Aging
HCBS Provider Organizations	
Phil Pangrazio, *President and CEO*	Ability 360 (AZ)
Darby Anderson, *Executive Vice President and Chief Development Officer, PMHC Vice Chair and Chair of the Policy Committee*	Addus HomeCare/Partnership for Medicaid Home-Based Care (PMHC)

Structured interview guides were created that focused on gaining input focused on the following:

A. Integrated managed care program care coordination standards – whether they are over prescriptive or under prescriptive;
B. How health plans operationalize care coordination standards – what worked well and what was challenging;
C. What standards may result in promising care coordination practices and outcomes – for the broad dually eligible population and for dually eligible sub-populations (e.g., elderly, physically disabled, individuals with intellectual and developmental disabilities [IDD]; individuals with more intense behavioral health issues);

D. Gaps in standards and how they were addressed by the health plan and federal and state officials;
E. Approaches to stakeholder engagement into the development and ongoing oversight of care coordination requirements – successes and challenges; and
F. Suggestions for refining care coordination standards for the dually eligible population in enrolled in integrated managed care plans.

Finally, HMA analyzed notes from each interview to identify trends, perspectives and unique approaches to current and planned care coordination standards.

Appendix B: Summary of Care Coordination Contract Provisions for Medicare-Medicaid Integrated Managed Care Models via Managed Care Organizations

I. Review Findings

Across the contracts and three program models, the definitions and terminology for care coordination varied. In some cases, care coordination activities were embedded in multiple processes such as care management and case management; in other cases, coordination functions were part of one comprehensive process. Terms with overlapping definitions included: care coordination; enhanced care coordination; service coordination; care management; and case management. Similarly, the titles for the individuals performing the coordination differed across contracts, sometimes with multiple titles in one contract reflecting different qualifications and specific roles (e.g., care coordinator, service coordinator, community health worker, support coordinator). "Care coordinator" is used to cover all references to these functions, unless citing specific contract language.

Contract review findings are listed for each integrated care model as follows: A) MLTSS+D-SNP; B) FIDE SNP; and C) Capitated FAIs. Each integrated care model section covers the following: 1) Care Coordinator Qualifications and Training; 2) Care Coordinator Caseload Ratios; 3) Family/Caregiver Involvement; 4) Subcontractor and Function; 5) Health Risk Assessment (HRA); 6) Individualized Care Plan (ICP); 7) Interdisciplinary Care Team (ICT); 8) Social Determinants of Health (SDOH); 9) Transitions of Care (TOC); 10) Data/IT/Reporting; and 11) Stakeholders.

A. MLTSS+D-SNP

The state Medicaid managed long-term services and supports (MLTSS) program contracts (and Medicaid managed care contracts including MLTSS) between the state and health plan specify care coordination for Medicaid services, and may reference care coordination requirements with the Medicare and Medicaid dually eligible beneficiaries' Medicare Advantage (MA) dual eligible special needs plan (D-SNP), should they be enrolled in one. There is variation across states as to the level of specificity in provisions and requirements for care coordination across MLTSS and D-SNP plans. Key contract areas below note requirements found in MLTSS+D-SNP model contracts.

1. Care Coordinator Qualifications and Training

State requirements for care coordinator qualifications vary in detail but require a degree in social work or related field or being a registered nurse (RN) or licensed practical nurse (LPN), and, sometimes substitute degree for having a specified number of years of related experience. For example, Florida allows for different scenarios with increased number of years of experience in place of degree(s). Of the D-SNP contracts reviewed, Virginia had a provision stating that care coordinators must be trained on available Medicaid benefits and coordination of Medicare and Medicaid benefits, as well as the coordination of benefits and cost sharing between Medicare and Medicaid.

TABLE 1. MLTSS+D-SNP CARE COORDINATOR QUALIFICATIONS AND TRAINING REQUIREMENTS

Contract	*Requirements*	*Other Specifications*
AZ MLTSS	•Degree in Social Work OR •Licensed registered nurse (RN) OR •Experience serving persons who are elderly, with physical or developmental disabilities and/or have severe mental illness	
FL MLTSS	**Scenario 1:** •BA in social work, sociology, psychology, gerontology or related field OR Licensed RN •2 years of experience **Scenario 2:** •Licensed practical nurse (LPN) with license •4 years of experience **Scenario 3:** •Master's degree in social work, sociology, psychology, gerontology or related social services •2 years of experience **Scenario 4:** •6 years of experience	•4 hours of in-service training on identifying abuse, neglect and exploitation annually. •One staff person needs to be designated as an expert on housing, education, employment, behavioral health and employment issues •For special subpopulations, must have experience or training in case management techniques for such populations
HI – MLTSS+D-SNP	•Social worker, nurse or other health care professional •1 year of relevant healthcare experience	
MN MLTSS+ D-SNP	•Social worker, public health nurse, RN, physician assistant (PA), nurse practitioner (NP) or physician	
TN MLTSS	**Care Coordinator:** •BA in social work, nursing or other health care profession OR •Licensed RN or LPN **Support Coordinator:** •BA in social work, nursing, education, rehabilitation or other human service/healthcare profession OR •Licensed RN or LPN, with a preference for those with a Certification from the Developmental Disabilities Nurses Association OR •5 years of experience for an 1915(c) home and community-based services (HCBS) wavier and completed specific workshops OR •Meet requirements for Qualified Developmental Disabilities Professional	
TX MLTSS	**Service Coordinator** •BA/Master's in social work or related field OR •Licensed RN, licensed vocational nurse (LVN), advanced practice nurse (ANP) or PA **Level 1 Service Coordinator:**	

Contract	Requirements	Other Specifications
	•Resource Utilization Group (RUG)-certified RN or NP **Level 2 or 3 Service Coordinator:** •BA/Master's in social work or related field OR •Licensed LVN, RN, NP, PA or qualified intellectual or developmental disabilities (IDD) professional OR •3 recent years of experience with aged, blind, or disabled (ABD)/Supplemental Security Income (SSI) population	
VA MLTSS	•BA in health or human services field OR •Licensed RN or LPN •All Care Coordinators must have 1 year of experience directly working with individuals who meet Commonwealth Coordinated Care Plus (CCC Plus) criteria	•Must complete a comprehensive training curriculum on members' behavioral and medical health needs and the CCC Plus program
VA D-SNP		•Must be trained on available Medicaid benefits and coordination of Medicare and Medicaid benefits, as well as the coordination of benefits and cost sharing between Medicare and Medicaid.

2. Care Coordinator Caseload Ratios

Medicaid MLTSS contracts contained care coordinator caseload ratio provisions, but only Virginia and Hawaii specified maximum caseloads for dually eligible beneficiaries as a separate population. Hawaii specified 1:750 and Virginia 1:100 for dually eligible beneficiaries, presumably referring to dually eligible beneficiaries that do not meet criteria of another category requiring a lower caseload ratio (e.g., Hawaii HCBS - 1:50; Institutional level of care (LOC) - 1:120; Virginia High Risk - 1:70). No D-SNP contracts reviewed required caseload ratios or submission of caseload ratio methodology to the state for approval.

TABLE 2. MLTSS+D-SNP CASELOAD RATIOS (MAXIMUM ENROLLEES PER CARE COORDINATOR)

Contract	Care Coordinator Ratios	Specific Populations	Other
AZ MLTSS	Not to exceed a weighted value of 96		
FL MLTSS	1:60	For those under age 21: 1:40 for private duty nursing 1:100 for nursing facilities (NF) 1:15 for skilled nursing facilities (SNF)	
HI MLTSS+D-SNP	Children - 1:200 Adults - 1:250	Home and community-based services (HCBS) - 1:50 Institutional level of care (LOC) - 1:120 Dually eligible - 1:750	

Contract	*Care Coordinator Ratios*	*Specific Populations*	*Other*
MN MLTSS+D-SNP			MCO may establish and submit to state for review
TN MLTSS	Average - 1:115 Maximum - 1:165		Weighted by Group Type (1-6)
TX MLTSS			Health maintenance organization (HMO) must monitor to ensure performance
VA MLTSS		High Risk - 1:70 NF - 1:175 Dually eligible - 1:100 Emerging High Risk - 1:400	

3. Family/Caregiver Involvement

No references to family and other caregiver involvement were specific to dually eligible beneficiaries. Inclusion of family and other caregivers were applicable to all enrolled individuals with the health plans. Provisions in MLTSS contracts included:

- Arizona: Case managers must allow the member and family or representative to identify their role in interacting with the service system. A basic tenet of case management is to ensure involvement of the member and the member's family in making informed decisions and identifying strengths and needs of the member, including developing the service plan.
- Arizona: Enrollees can invite anyone of their choosing to be involved in the development of the care plan and HRA, but there are no firm requirements for family and other caregiver involvement.
- Hawaii: Members can determine who must be part of developing the service plan, including family members, caregivers and significant others.
- Minnesota: The managed care organization (MCO) must have a strategy to involve enrollees and family members or guardians involved in treatment planning and care planning. The MCO must also provide caregiver supports and help facilitate caregiver respite.
- Tennessee: For individuals in Groups 2-6, caregiver assessments include review of family member(s) and/or caregiver(s) ability to provide care-giving services by assessing their physical and behavioral health, willingness to provide services, training needs, and any other supports needed. This assessment is conducted at least annually.
- Texas: The MLTSS MCO must identify and train members or their families to coordinate their own care, to the extent of their capability and willingness to coordinate care.
- Virginia: Members are encouraged to identify individuals they would like to participate on the interdisciplinary care team, including family members, but there are no requirements.

- Tennessee: The person-centered support plan (PCSP) must contain prioritized goals, a time frame for re-evaluation, resources to be utilized, a plan for continuity of care and include family participation. It must address the medical, social, educational and other services needed by the member.

4. Subcontractor and Function

Contracts reviewed did not contain any mandates that health plans subcontract care coordination responsibilities to specific entities, but two MLTSS contracts described acceptable entities for subcontracting:

- Minnesota: The health plan can contract with a county or multi-county entity for case management and related functions for MLTSS enrollees, referred to as County Case Management Systems.
- Virginia: The contractor can subcontract with Community Based Organizations (e.g., Centers for Independent Living, Community Services Boards, or Area Agencies on Aging) for care coordination services, but the contractor must ensure that all staff and supervisors meet the contractual standards.

5. Health Risk Assessment (HRA)

Except for Arizona, Tennessee and Virginia, MLTSS plans and D-SNP contracts did contain HRA requirements specific to dually eligible beneficiaries. Most states' general HRA requirements would cover these individuals but are not specifically tailored to their needs as dually eligible beneficiaries with full Medicaid and Medicare benefits. Of note, Virginia requires D-SNPs to request a representative from an enrollee's Medicaid plan to participate in all needs assessments, person-centered planning and all interdisciplinary care team meetings.

D-SNP HRA References to Dually Eligible Beneficiaries

- Arizona: The D-SNP health plan is required to submit the Medicare Health Risk Assessment Tool.
- Tennessee: For members receiving LTSS enrolled in a D-SNP, the HRA must be integrated with its Comprehensive Needs Assessment and Person-Centered Support Plan and the contractor shall participate, upon request, in the needs assessment encompassing both Medicare and Medicaid benefits.
- Virginia: The D-SNP shall request a representative from the enrollee's Medicaid plan to participate in all needs assessments and must provide the Medicaid plan with the results of the assessments.

MLTSS HRA Provisions without Reference to Dually Eligible Beneficiaries

- Arizona: Initial contact and periodic service review must take place with the member and family/representative within appropriate timeframes.
- Florida: The health assessment must combine a health history, physical assessment and the monitoring of physical and psychological growth and development. It shall be

conducted in-person within 5 days of enrollment and the enrollee can invite anyone of their choosing. The plan must use agency-required forms and shall be reassessed annually, at a minimum.

- Hawaii: A Health and Functional Assessment (HFA) shall be conducted face-to-face within 7 days of enrollment, using a standardized DHS form and the State's LOC evaluation tool if applicable. The HFA needs to take into account the health status (including activities of daily living and instrumental activities of daily living), environment, available supports, medical history and social history. Each member shall be re-assessed every 6 months or with a change in condition. For those receiving LTSS, the member shall be reassessed quarterly and if they are in a residential setting, they shall be re-assessed semi-annually.
- Minnesota: An initial risk screening and assessment shall take place within 60 (30 days for Elderly Waiver enrollees) days of enrollment and reassessed annually by phone, mail or face-to-face. It must address medical, social, environmental and mental health factors. This can include Long-Term Care Consultation (LTCC) assessments to determine access to HCBS and/or home care services.
- Tennessee: An HRA must take place within 30 days and be conducted annually. The assessment varies by group type and could include other needs such as health, functional, or quality of life outcomes (Groups 1-6); financial health, employment, natural supports, food security (Groups 2-3); and the member's strengths, goals and needs (Groups 4-6). Those in Groups 2-6 must also undergo a caregiver assessment to review caregiver(s) ability to provider services, which is also conducted annually.[4]
- Texas: The health plan must have a system and procedure for identifying members with Special Health Care Needs.
- Virginia: The HRA, for most members, must take place within 60 days of enrollment (face-to-face only required for those with severe mental illness) and must identify unmet needs, include SDOH, functional, medical, behavioral, cognitive, LTSS, wellness and preventive domains, strengths and goals, community resources, need for specialists, and the member's desires.

6. Individualized Care Plan (ICP)

Most contract provisions related to ICPs did not specifically make reference to dually eligible beneficiaries. Tennessee and Virginia are exceptions. Tennessee's MLTSS contract states that the MLTSS contractor may request D-SNP participation in the integrated person-centered

[4] TN MLTSS program stratifies enrollees into 6 groups based on age, functional and risk level, and other criteria. (State of Tennessee, Department of Finance and Administration, Division of Health Care Finance and Administration, Division of TennCare, *Statewide Contract with Amendment 7 – January 1, 2018,* (TennCare, 2018).)

service plan (PCSP) process which covers Medicare and Medicaid benefits. The plan is then submitted to the member's D-SNP. The TN D-SNP is required to incorporate LTSS D-SNP members' plan of care with the TN MLTSS PCSP. Virginia requires D-SNPs to request a representative from an enrollee's Medicaid plan to participate in all needs assessments, person-centered planning and all interdisciplinary care team meetings.

ICP References to Dually Eligible Beneficiaries

- Tennessee MLTSS: For D-SNP participants, the contractor can request D-SNP participation in the integrated PCSP that encompasses Medicare and Medicaid benefits and the PCSP must then be submitted to the member's D-SNP.
- Tennessee D-SNP: For LTSS D-SNP members enrolled in aligned MLTSS and D-SNP plans, the assessment and plan of care must be integrated with the TennCare assessment and PCSP.
- Virginia D-SNP: D-SNP shall request a representative from the enrollee's Medicaid plan to participate in all needs assessments, person centered planning and all Interdisciplinary Care Team meetings.

MLTSS ICP Provisions without References to Dually Eligible Beneficiaries

- Arizona: The case management process involves a review of the member's strengths and needs by the member, their family or representative and the case manager. The review must result in an appropriate and cost-effective service plan the meets the medical, functional, social and behavioral health needs of the member in the most integrated setting.
- Florida: The plan of care must describe the service needs of each enrollee; the projected duration, desired frequency, type of provider for each service, and the scope of services to be provided. It shall be conducted within 5 days of enrollment, and re-assessed annually, and the enrollee can invite anyone of their choosing.
- Hawaii: The service plan is based upon the Health and Functional Assessment and must include problem identification; goals, objectives and desired outcomes; and interventions. The plan must consider the appropriate mix of services that will enable the member to remain in their home or community to delay institutionalization. The plan must be developed with the member and the member can be joined by family members, significant others, caregivers, etc. and shall be reassessed annually.
- Minnesota: Care plan is developed with the enrollee, treating physician, other healthcare personnel, the enrollee's family, caregiver, or representative. The care plan is based on the needs assessment and must incorporate an interdisciplinary, holistic and preventive focus and must provide caregiver supports and respite to assist the enrollee to remain in the home, along with informal supports. The plan must be reassessed annually in face-to-face visits.
- Texas: The service plan is developed with and for members with Special Health Care Needs and must include current medical and social needs, goals, a list of services and

their frequency, and providers of those services. It may also include information for services outside covered benefits, such as affordable housing.

- Virginia: The ICP is written with the member that specifies their services and supports and shall incorporate their strengths, skills, needs (medical, social, behavioral and LTSS), preferences and goals. For most members, the ICP must be completed within 90 days of enrollment.

7. Interdisciplinary Care Team (ICT)

Few contracts specifically reference dually eligible beneficiaries as a separate, discrete population for ICT activities. Tennessee MLTSS contract requires that the team coordinate with Medicare Advantage plans as appropriate. Virginia references that a Medicaid MLTSS plan may request a representative from the enrollee's Medicare plan to participate in ICT meetings. The state additionally requires D-SNPs to request a representative from an enrollee's Medicaid plan to participate in all needs assessments, person centered planning and all ICT meetings.

ICT References to Dually Eligible Beneficiaries

- Tennessee MLTSS: If a coordination team is used, it must consist of the member's care or support coordinator and other specific persons as relevant. The team must coordinate with Medicare payers, MA plans, and Medicare providers as appropriate.
- Virginia MLTSS: Medicaid MLTSS plans may request a representative from the enrollee's Medicare plan, as applicable, to participate in ICT meetings.
- Virginia D-SNP: D-SNP shall request a representative from the enrollee's Medicaid plan to participate in all needs assessments, person centered planning and all Interdisciplinary Care Team meetings.

MLTSS ICT Provisions without References to Dually Eligible Beneficiaries

- Arizona: The interdisciplinary care team must address the totality of the treatment and service plans for the member.
- Hawaii: The service coordinator is responsible for coordinating a team of decision-makers to develop the service plan that must include the PCP, other providers as needed, the member and others determined by the member.
- Texas: The HMO must have effective systems to ensure members have access to treatment by a multidisciplinary team when the member's PCP determines it is medically necessary and the team must participate in hospital discharge planning, pre-admission hospital planning, developing specialty care recommendations for the service plan, and providing information regarding specialty care recommendations to the member.
- Virginia: The ICT must employ both medical and social models of care to ensure that each member's care is integrated and coordinated. The team must include the member, the care coordinator, PCP, behavioral health clinician, LTSS providers if applicable, and pharmacist if indicated. It could also include a representative from the Medicare plan, RN, specialty clinicians, family members, other informal caregivers and supports, and

advocates. The initial ICT meetings, for most members, must take place within 90 days of enrollment and team members must be given at least a 1-week notice

8. Social Determinants of Health (SDOH)

References to care coordinator responsibilities did not include any specific requirements for dually eligible beneficiaries, but these beneficiaries would particularly benefit from the care coordination activities addressing SDOH. Reference to care coordinator responsibilities related to SDOH varied in level of detail from identifying and facilitating access to community resources to specifically requiring that a staff person be designated as an expert on housing, education and employment resources. Some contracts referred to "social services". Florida MLTSS requires that case managers be trained on local resources for housing, education and employment issues and resources. The Tennessee MLTSS contract requires that care coordination include identification of social support services and assistance, with examples of housing and income assistance, necessary to meet the identified needs the care coordinator is responsible for assessing, identifying, addressing. The care coordinator is responsible for facilitating access to those services. Virginia MLTSS contracts require health plans to establish programs or establish partnerships to address social factors that affect health outcomes. Virginia MLTSS contracts require that care coordination must identify and address member access to education, housing services, job training, food security, transportation needs, and resources that support member connection to social supports. Four specific areas of concentration are called out that the contractor must address and report upon annually: (1) Economic Stability; (2) Education; (3) Social and Community; and (4) Health and Health Care.

MLTSS SDOH-Related Provisions

- Arizona: Case managers must facilitate access to non-ALTCS services available in the community, assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in areas of housing, education and employment. There also needs to be a staff person designated as the expert on housing, education and employment issues and resources in the service area.
- Florida: Case managers must be trained on local resources for housing, education and employment services and programs that can help enrollees gain greater self-sufficiency. There also needs to be a staff person designated as the expert on housing, education and employment issues and resources in the service area.
- Hawaii: Service coordinator must facilitate access to community services and coordinate with those services to the extent appropriate.
- Minnesota: Case management includes using a method for coordinating enrollee medical needs with social service needs.
- Tennessee: The contractor must use care coordination to identify social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified

needs the care or support coordinator is responsible for assessing, identifying, addressing and facilitating access to those services.

- Texas: Specialized care management services performed include coordination of plan services with social and other services delivered outside of the plan as necessary. The plan may include information for services outside the scope of covered benefits, such as how to access affordable housing.
- Virginia: The contractor must develop programs or establish partnerships to address social factors that affect health outcomes. Care coordination/case management must identify, address member access to education, housing service, job training, food security, transportation needs, and resources that support member connection to social supports. Four specific areas of concentration are called out that the contractor must address and report upon annually: (1) Economic Stability; (2) Education; (3) Social and Community; and (4) Health and Health Care.

9. Transitions of Care (TOC)

Arizona, Tennessee and Virginia MLTSS contracts include requirements for transitions between acute and non-acute care settings for dually eligible beneficiaries. Arizona requires that a contact must be established at the Medicaid plan that is responsible to share timely inpatient hospital, emergency room, and chronic illness information to assist with care coordination when benefit coverage switches from Medicare to Medicaid. Tennessee requires plans to coordinate with a member's D-SNP regarding discharge planning from any inpatient setting or observation when Medicaid services may be needed upon discharge. The state additionally requires its D-SNPs to coordinate Medicaid benefits with dually eligible beneficiary's Medicaid MLTSS plan and must provide notifications to the plan of inpatient admissions, emergency room visits and observation days, as well as coordinate discharge planning with the Medicaid plan when Medicaid services are needed upon discharge. Virginia MLTSS plans must have a least one dedicated transition care coordinator in each region of the state to assist with care transitions from institutional settings into the community. The state also requires D-SNPs to provide MLTSS plans with timely inpatient hospital, emergency room and nursing facility admissions and discharges (48 hours) and the diagnosis of, or significant change in the treatment of, a chronic illness (72 hours) to facilitate the coordination of benefits and cost sharing between the MA D-SNP and Medicaid plan. This includes coordinating with the Medicaid MCO regarding discharge planning.

TOC References to Dually Eligible Beneficiaries

- Arizona MLTSS: A contact must be established at a Medicaid plan that will be responsible to share timely inpatient hospital, ER, and chronic illness information to assist with care coordination when benefit coverage switches from Medicare to Medicaid.
- Tennessee MLTSS: Must coordinate with a member's D-SNP regarding discharge planning from any inpatient setting or observation when Medicaid services may be needed upon discharge (LTSS, home health, private duty nursing, etc.).

- Tennessee D-SNP: D-SNP is to coordinate TennCare benefits with the dual eligible member's health plan and is responsible for providing notifications to the health plan regarding inpatient admissions, ED visits, and observation days. It must also coordinate with the health plan regarding discharge planning from an inpatient setting when Medicaid services may be needed upon discharge, including following up with dual eligible members and their health plan to address member needs and coordinate Medicaid benefits as appropriate.
- Virginia MLTSS: Contractor must have at least one dedicated transition care coordinator in each region to assist with care transitions from institutional settings into the community and helping those who wish to remain in the community. The transition care coordinator must work with the member's care coordinator to ensure safe and effective transitions and for dually eligible beneficiaries the transition coordinator must work with the DSNP care coordinator to coordinate activities.
- Virginia D-SNP: D-SNP shall provide the Medicaid plan with timely inpatient hospital, ED and NF admissions and discharges (48 hours) and the diagnosis of, or significant change in the treatment of, a chronic illness (72 hours) to facilitate the coordination of benefits and cost sharing between the MA D-SNP and Medicaid plan. This includes coordinating with the Medicaid plan regarding discharge planning.

MLTSS TOC Provisions without References to Dually Eligible Beneficiaries

- Florida: Policies must be in place that address the coordination of discharge planning and post-discharge care and includes the hospital/institution care coordinator case manager.
- Hawaii: Coordinator must provide continuity of care when members are discharged from a hospital.
- Minnesota: Hospital In-Reach Community-based Service Coordination (IRSC) that is performed through a hospital ER for enrollees who frequent the ER 3 or more times in the previous 4 months. Service coordination includes an assessment to address mental health, chemical health, social, economic, and housing needs and other services needed to reduce ER and other non-medically necessary health care.
- Texas: HMO must have a protocol for quickly assessing the needs of members discharged from a hospital or other treatment facility by working with other relevant care coordinators and providers.

10. Data/IT/Reporting

A number of states require data reporting specific to the dually eligible population. In Tennessee, D-SNPs must submit annual Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPs), and Health Outcomes Survey (HOS) data to the state, as well as quarterly reports on dually eligible beneficiaries' coordination, seamless conversion, and D-SNP appeals and grievances. Virginia

requires that MLTSS MCOs submit policies and procedures of its electronic system and other tools care coordinators will use to integrate care for members, including integrating Medicare for dually eligible beneficiaries. Virginia additionally requires D-SNPs to submit information on a "D-SNP Dashboard," and to submit monthly enrollment reports and all information requested on the dashboard including the number of times the D-SNP requested the presence of the Medicaid MLTSS plan, number of unaligned enrollee emergency department visit information sent to the Medicaid MLTSS plan, and the number of unaligned members with chronic illness and/or conditions.

The Tennessee MLTSS contract contained the most extensive requirements related to MCO IT systems data sharing with D-SNPs for coordination for fully dually eligible beneficiaries. The IT system must do the following:

- Modify its IT systems to accept Medicare enrollment data and to load the data in the plan's case management system for use by care/support coordinators and case management, disease management, population health and utilization management staff.
- Be structured to facilitate the coordination of Medicaid and Medicare services in an integrated way.
- Support coordination with a member's D-SNP regarding discharge planning from any inpatient setting or observation stay when Medicaid LTSS (nursing facility or HCBS), Medicaid home health or private duty nursing, or other Medicaid services may be needed upon discharge.
- Receive and process a standardized electronic Daily Inpatient Admissions, Census and Discharge Report from each D-SNP in the Grand Region served.
- Ensure that all required notifications from the member's D-SNP of inpatient admission (both planned and unplanned from hospitals or SNFs), of observation days and any emergency room visits are timely and appropriately triaged.
- Daily reports must be maintained to determine appropriate and timely engagement in discharge planning.

IT References to Dually Eligible Beneficiaries

- Arizona D-SNP: Arizona Health Care Cost Containment System (AHCCCS) will ensure that the D-SNP plan has access to the dually eligible member's AHCCCS acute or Arizona Long Term Care System (ALTCS) Medicaid plan enrollment through daily files ad online and the D-SNP will be able to verify Medicaid eligibility in real-time. The D-SNP health plan must establish a contact at each plan that will be responsible to share inpatient hospital, ER and chronic illness information to the acute or Medicaid plan.
- Tennessee D-SNP: The plan must submit annual HEDIS, CAHPs, and HOS data to TennCare and for D-SNP plans, they must also submit MA Star Quality ratings and quarterly reports on dually eligible beneficiaries' coordination, seamless conversion, and D-SNP appeals and grievances.

- Tennessee MLTSS: For coordination with D-SNPs regarding the plan's Full Benefit Dual Eligible (FBDE) members enrolled in a D-SNP, the plan needs to modify its IT systems to accept Medicare enrollment data and to load the data in the plan's case management system for use by care/support coordinators and case management, DM/Population Health and UM staff. The system shall be structured to facilitate the coordination of Medicaid and Medicare services in an integrated way. The contractor must coordinate with a member's D-SNP regarding discharge planning from any inpatient setting or observation stay when Medicaid LTSS (NF or HCBS), Medicaid home health or private duty nursing, or other Medicaid services may be needed upon discharge. The contractor must also receive and process a standardized electronic Daily Inpatient Admissions, Census and Discharge Report from each D-SNP in the Grand Region served. The contractor must ensure that all required notifications from the member's D-SNP of inpatient admission (both planned and unplanned from hospitals or SNFs), of observation days and any ER visits are timely and appropriately triaged. Daily reports must be maintained to determine appropriate and timely engagement in discharge planning. It must provide the D-SNP enrollment files of dually eligible beneficiaries over monthly reporting periods to confirm eligibility.
- Virginia MLTSS: The MCO must have an electronic care coordination system. The goal of the IT system is to integrate data and information among the contractor, service areas, helplines, providers, members, and care coordinators to better coordinate care, follow members through episodes of care, and streamline care transitions. Member-facing staff must have immediate/real-time access to the system. The contractor must submit at implementation, at revision or upon request, the policies and procedures of its electronic system and other tools care coordinators will use to integrate care for members, including integrating Medicare for dually eligible members.
- Virginia D-SNP: The D-SNP must submit monthly enrollment reports and all information requested on the "DSNP Dashboard" including the number of times the D-SNP requested the presence of the Medicaid plan, number of unaligned enrollee ED visits information sent to the Medicaid MLTSS plan, and the number of unaligned with chronic illness/conditions.

IT Provisions without Reference to Dually Eligible Beneficiaries

- Florida MLTSS: The plan must conduct quarterly case file audits and reviews of the consistency of enrollee assessments, along with reports that demonstrate case management monitoring and evaluation (including level of care assessments, staff meeting training requirements, plan of care audits).
- Hawaii MLTSS: The health plan must facilitate and integrate these key service coordination functions: health status assessments, optimal mix of health care services service plans, coordination and oversight of delivery of services, and utilization and outcomes data.

- Minnesota MLTSS: The contractor must report on their care coordination and case management systems annually how care coordination is provided, who is providing the care coordination, a description of all care coordination screenings and tools, and any trainings of care coordinators.
- Tennessee MLTSS: The plan must develop or purchase an electronic visit verification system (EVV) system for CHOICES HCBS members. All admission, discharge and transfer data from applicable hospitals must be made available to all PCPs. The plan is also responsible for service coordination reports, submitted either monthly or quarterly, on care coordination (including staffing, enrollment, assessments, and service initiation), support coordination, caseload and staffing ratio reports, and meeting the urgent needs of members during transition.
- Texas MLTSS: The HMO's (management information system) system must be able to, among other things, track covered services, transmit or transfer encounter data, accommodate the coordination of benefits, maintain and cross-reference all member-related information.

11. Stakeholders

Contracts reviewed had few, if any, requirements for stakeholder engagement specific to dually eligible individuals and care coordination.

B. FIDE SNP

The state may have one comprehensive MLTSS+FIDE SNP contract that details all Medicaid and Medicare program responsibilities with the state including care coordination. Those states include California, Idaho, Massachusetts, Minnesota and Wisconsin. The remaining states with FIDE Programs have separate Medicaid MLTSS or managed care contracts and FIDE SNP contracts detailing health plan responsibilities and are also CMS designated FIDE SNPs eligible to receive the frailty adjustment.[5] Below are care coordination-related requirements found in FIDE SNP program model contracts and related Medicaid MLTSS contracts. In sections below, "*References to Dually Eligible Beneficiaries*" includes all relevant FIDE SNP contract provisions because these contracts are specific to dually eligible individuals.

1. Care Coordinator Qualifications and Training

Similar to contract review findings for MLTSS+D-SNP models, state requirements for care coordinator qualifications vary in detail but generally require a degree in social work or related field or being a RN or LPN, and/or having a specified number of years of related experience.

[5] The Health and Human Services Secretary has the authority to apply a frailty adjustment payment under the rules for Program of All-Inclusive Care for the Elderly (PACE) payment, for certain FIDE SNPs, to reflect the costs of treating high concentrations of frail individuals. Every fall, CMS notifies each FIDE SNP of its frailty score and of how it compares to PACE organizations. (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid, *Medicare Managed Care Manual, Chapter 16-B: Special Needs Plans*, Rev. 123, Issued: 08-19-16)

Florida allows for different scenarios with increased number of years of experience in place of degree(s).

TABLE 3. FIDE SNP QUALIFICATIONS AND TRAINING TABLE

Contract	*Requirements*	*Other Specifications*
AZ MLTSS	•Have a degree in social work OR •Be a licensed registered nurse (RN) OR • Have experience serving persons who are elderly and/or persons with physical or developmental disabilities and/or members determined to have severe mental illness.	
CA FIDE		Nothing specific to case/care managers
FL MLTSS	**Scenario 1:** •BA in social work, sociology, psychology, gerontology or related field OR Licensed RN •2 years of experience **Scenario 2:** •Licensed practical nurse (LPN) with license •4 years of experience **Scenario 3:** •Master's degree in social work, sociology, psychology, gerontology or related social services •2 years of experience (1 year can be substituted with practicum, internship or rotation) **Scenario 4:** •6 years of experience	•4 hours of in-service training on identifying abuse, neglect and exploitation annually. •One staff person needs to be designated as an expert on housing, education, employment, behavioral health and employment issues •For special subpopulations, must have experience or training in case management techniques for such populations
ID MLTSS+FIDE SNP	**Care Coordinators:** •Licensed RN, LPN, physician assistant (PA) or licensed social worker (LSW) OR •2-year degree and at least 2 years of experience in healthcare or healthcare - related industry	Non-licensed individuals may only perform as Care Coordinators if they operate under direct oversight of a RN, PLN, PA or LSW
MA MLTSS+FIDE SNP		The Contractor must establish its own written qualifications for a Geriatrics Support Services Coordinator (GSSC)
MN MLTSS+FIDE SNP	• Must be a social worker, public health nurse, RN, PA, nurse practitioner (NP) or physician.	
NJ MLTSS+FIDE	**Level 1:** •Licensed LPN, RN OR •BA in social work, health or behavioral science	Shall include Care Managers with experience working with pediatric as well as adult enrollees with special needs. Shall also have knowledge or experience in

Contract	*Requirements*	*Other Specifications*
	Level 2: •Level 1 Requirements AND •1 year of experience serving individuals with special needs **Higher Levels:** •Licensed RN and 3 years of experience serving individuals with special needs OR •Graduate degree with 2 years of experience serving individuals with special needs	interviewing and assessing members; caseload management and casework practices; human services principles for determining eligibility; ability to effectively solve problems and locate community resources; and the needs and service delivery system for all populations in their caseload.
NY - Medicaid Advantage Plus	Not specified	
TennCare MLTSS	**Care Coordinator:** •BA in social work, nursing or other health care profession OR •Licensed RN or LPN **Support Coordinator:** •BA in social work, nursing, education, rehabilitation or other human service/healthcare profession OR •Licensed RN or LPN, preferred to have a Certification from the Developmental Disabilities Nurses Association OR •5 years of experience for an 1915(c) home and community-based services (HCBS) wavier and completed specific workshops •Meet requirements for Qualified Developmental Disabilities Professional	
WI MLTSS/FIDE/PACE	**Social service coordinator**: •Certified social worker OR •BA in human service area OR BA in another field with 3 years of experience in social service care management	

2. Care Coordinator Caseload Ratios

MLTSS contracts tend to specify caseload ratios. MLTSS+FIDE SNP single contracts for Idaho, Massachusetts and Minnesota programs gave plans flexibility to develop and submit caseload ratios to the state for approval.

TABLE 4. FIDE SNP CASELOAD RATIOS TABLE

Contract	*Case Manager Ratios*	*Specific Populations*	*Other*
AZ MLTSS	Caseload may not exceed a weighted value of 96.		
CA MLTSS+FIDE	Not specified for case managers		
FL MLTSS -	1:60	For those under age 21: 1:40 for those receiving private duty nursing services 1:100 for those in nursing facility (NF) 1:15 for enrollees in a skilled nursing facility (SNF)	
Idaho FIDE SNP			Provides flexibility to managed care organizations (MCO) to define at least three risk stratification levels and related criteria, including staff ratios
MA MLTSS+FIDE SNP	Not specified		
MN MLTSS+FIDE SNP			MCO shall establish policies and criteria for caseload ratios and submit policies and procedures to state for review
NJ MLTSS +FIDE	1:120 (weighted value)	1:240 for NF 1:120 for home and community-based services (HCBS) in alternative community setting 1:60 for HCBS 1:48 for pediatric Special Care NF	Contractor must monitor caseload and adjust as needed to meet the needs of the entire case mix.
NY - Medicaid Advantage Plus	Not specified		
TN MLTSS	Average cannot exceed 1:115 Maximum caseload cannot exceed 1:165		These ratios are weighted by member group type (1-6)
WI MLTSS/FIDE/PACE	Not specified		

3. Family/Caregiver Involvement

Family/Caregiver involvement contract provisions ranged from including family and other caregivers in enrollee assessments and making informed decisions, to identifying need for and providing family/caregiver support. Idaho's FIDE SNP contract requires that health home providers utilize available family supports. The Tennessee MLTSS contract requires conducting assessments of family and other caregivers that provide caregiving services to identify needs. Massachusetts' FIDE SNP contract requires that the health plan's centralized enrollee record (CER) document contacts with family members and persons providing informal supports.

Family and Caregiver Involvement-related Provisions

- Arizona MLTSS: Case managers must allow the member and family/representative to identify their role in interacting with the service system. A basic tenet of case management is to ensure involvement of the member and the member's family in making informed decisions and identifying strengths and needs of the member, including in developing the service plan.
- Idaho FIDE SNP: A health home provider must coordinate in a way that utilizes available individual and family supports to maintain the health of the enrollee.
- New Jersey MLTSS+FIDE: The health plan must, at a minimum, make use of family members to identify each member's needs for the development of the care plan and the frequency and intensity of care coordination.
- Massachusetts FIDE SNP: The Centralized Enrollee Record (CER) must contain the documentation of contacts with family members and persons giving formal support.
- Minnesota FIDE SNP: The MCO must have a strategy to involve enrollees and/or family members or guardians involved in treatment planning and care planning. The MCO must also provide caregiver supports and help facilitate caregiver respite.
- Tennessee MLTSS: For individuals in Groups 2-6, caregiver assessments are given to review family member(s) and/or caregiver(s) ability to provide care-giving services by assessing their physical and behavioral health, willingness to provide services, training needs, and any other supports needed. This assessment is conducted at least annually.

4. Subcontractor and Function

One state with FIDE SNPs mandates subcontracting for care coordination functions. Massachusetts requires plans to subcontract with Aging Service Access Points (ASAPs) for Geriatrics Support Services Coordinator (GSSC) services. Minnesota specifies the health plan can contract with a county or multi-county entity for case management and related functions referred to as County Case Management Systems.

5. Health Risk Assessment (HRA)

A few contracts for FIDE SNP programs, Florida, Idaho and Tennessee, specifically address support for use of an integrated Medicare and Medicaid Health Risk Assessment.

FIDE SNP contract HRA References to Dually Eligible Beneficiaries

- Florida: An integrated Medicare and Medicaid Health Risk Assessment must be performed upon enrollment and annually thereafter.
- Idaho: A Comprehensive Health Risk Assessment must be done for each new enrollee (within 20 to 90 days depending on risk stratification level) and reassessed annually. A standardized, person-centered and IDHW-approved instrument must be used that includes the member's current health status and treatment needs; social, employment, and transportation needs; personal goals; and informal support networks.
- Tennessee: For members receiving LTSS enrolled in aligned MLTSS and D-SNP plans, the HRA must be integrated with its Comprehensive Needs Assessment and Person-Centered Support Plan and the contractor must participate, upon request, in needs assessments encompassing both Medicare and Medicaid benefits.
- Massachusetts: Upon enrollment, an initial and ongoing assessments (every 6 months for those requiring complex care) must be performed, using an approved tool, and shall include the enrollee's clinical status, functional status, nutritional status and physical well-being; medical history; substance abuse screenings; and assessment of need for long-term care services, including informal supports.
- Minnesota: An initial risk screening and assessment must take place within 60 (30 days for Elderly Waiver enrollees) days of enrollment and re-assessed annually by phone, mail or face-to-face. It must address medical, social, environmental and mental health factors. This can include LTCC assessments to determine access to HCBS and/or home care services.
- Wisconsin: A comprehensive assessment, using a standard format developed, must identify the member's outcomes and the services and supports needed to support those outcomes and must include the member's resources, natural supports and community connections. It must be conducted face-to-face annually (or every 6 months for high-risk members).

MLTSS supplementing FIDE SNP HRA Provisions with No References to Dually Eligible Beneficiaries

- Arizona: An initial contact and periodic service reviews must take place with the member and family/representative within appropriate timeframes.
- Florida: The health assessment must combine a health history, physical assessment and the monitoring of physical and psychological growth and development. It shall be conducted in-person within 5 days of enrollment and the enrollee can invite anyone of their choosing. The plan must use agency-required forms and must be reassessed annually, at a minimum.
- New Jersey: A Health Risk Assessment, using a federal- or state-approved tool, must be conducted for new members to identify the enrollee's clinical, social, environmental, and functional risk factors.

- Tennessee: An HRA must take place within 30 days and conducted annually and must include screening for mental health and substance abuse for all members and screening for physical conditions when member condition is behavioral. The assessment varies by group type and could include other needs such as health, functional, or quality of life outcomes (Groups 1-6); financial health, employment, natural supports, food security (Groups 2-3); and the member's strengths, goals and needs (Groups 4-6). Those in Groups 2-6 must also undergo a caregiver assessment to review caregiver(s) ability to provider services, which is also conducted annually.

6. Individualized Care Plan (ICP)

Generally, the ICP covers the scope, frequency and duration of all covered services. Contract provisions additionally specify timeframes for when the ICP must be conducted for new enrollees and when they must be updated - at specified timeframes and/or upon change in condition. Arizona, Idaho, Minnesota, and Wisconsin contracts state that it shall also include how family members and social supports can be involved, as well as supported in care planning.

FIDE SNP ICP References to Dually Eligible Beneficiaries

- Idaho: The ICP must be completed within 120 days of enrollment (or within 30 days of the HRA) and must coordinate and integrate all covered and supplemental services, including behavioral health services. It shall also include how family member and social supports can be involved in the care planning, as well as the enrollee's health conditions; available treatment options, supports, and alternative courses of care; preferences for care; and goals and objectives. It must include the enrollee, their representative, and members of the ICT.
- Massachusetts: The ICP is a detailed description of the scope, frequency and duration of all covered services. It shall be developed by the PCP and must include written protocols for tracking and coordinating enrollee transfers from one setting to another.
- Minnesota: Care plan is developed with the enrollee, treating physician, other healthcare personnel, the enrollee's family, caregiver, or representative. The care plan is based on the need assessment and must incorporate an interdisciplinary, holistic and preventive focus and must provide caregiver supports and respite to assist the enrollee to remain in the home, along with informal supports. The plan must be conducted within 30 days of the HRA and must be reassessed annually in face-to-face visits.
- Wisconsin: The member centered plan (MCP) identifies services and supports provided or arranged by the MCO, including the frequency and duration of each service and the provider(s) that will furnish each service. The member must participate in the planning process and the MCP must include long-term care outcomes; personal experience outcomes; natural and community supports and a plan to sustain, maintain or enhance them; coordinating services outside the benefit and any risks. The MCP must be understandable to the member and their family member(s) and caregiver(s).

MLTSS contracts supplementing FIDE SNP - No ICP Provision References to Dually Eligible Beneficiaries

- Arizona: The case management process involves a review of the member's strengths and needs by the member, their family or representative and the case manager. The review must result in an appropriate and cost-effective service plan the meets the medical, functional, social and behavioral health needs of the member in the most integrated setting.
- Florida: The plan of care must describe the service needs of each enrollee; the projected duration, desired frequency, type of provider for each service, and the scope of services to be provided. It must be conducted within 5 days of enrollment, and re-assessed annually, and the enrollee can invite anyone of their choosing.
- Tennessee: The person-centered support plan (PCSP) must contain prioritized goals, a time frame for re-evaluation, resources to be utilized, a plan for continuity of care and include family participation. It must address the medical, social, educational and other services needed by the member.

7. Interdisciplinary Care Team (ICT)

Most contracts require the care coordinator and specified clinicians (e.g., PCP or RN) be part of the interdisciplinary care team. Idaho and Wisconsin contracts require that the interdisciplinary care teams facilitate access to social and community supports.

ICT References to Dually Eligible Beneficiaries

- Idaho FIDE SNP: The ICT shall integrate and coordinate each enrollee's care, including medical, behavioral, substance use and LTSS services and must include the enrollee, PCP, care coordinator, and behavioral health clinician (if appropriate). It can also include an RN, pharmacist, specialist, other support disciplines (ex. social workers), family members, caregivers, and advocates. The ICT must also facilitate access to other social support services to ensure each enrollee's health, safety and welfare and to delay/prevent the need for institutional placement.
- Massachusetts FIDE SNP: The Primary Care Team (PCT) consists of a PCP working with a GSSC, NP, RN or PA to assure effective coordination and delivery of care. The PCT arranges, delivers and monitors LTC services and determines appropriateness for institutional and community LTC services.
- Wisconsin FIDE SNP: The Interdisciplinary Team (IDT) includes the member and other people specified by the member, as well as the social service coordinator, RN and any other assigned staff. The IDT is responsible for coordinating the member's overall long-term care and health care and ensures the coordination of those services, as well as those available from natural and community supports. The entire IDT participates in assessment and re-assessments, including reviews of the member's preference regarding vocational or educational goals, including pursuing integrated employment.

The IDT must establish a schedule of face-to-face contacts, with a minimum of quarterly visits.

MLTSS contract supplementing FIDE SNP: ICT Provisions without References to Dually Eligible Beneficiaries

- Arizona: The interdisciplinary care team must address the totality of the treatment and service plans for the member.
- New Jersey: The MCO care manager must convene the ICT within 7 business days to review the member' circumstances with participants form the Contractor and the State (in context of cost-effectiveness analysis and HCBS).

8. Social Determinants of Health (SDOH)

The scope of contract care coordination provisions includes being responsible for services related to social supports and community services. A number of contracts specifically reference service needs related to SDOH such as housing, transportation, income assistance, and food security.

FIDE SNP SDOH References to Dually Eligible Beneficiaries

- Idaho: The care coordinator is responsible for coordinating services with the services the enrollee receives from community and social support providers. Health home providers must provide information on available community and social support services that aid in promoting healthy behaviors and reducing physical and mental health risk factors.
- Massachusetts: The GSSC is responsible for arranging, coordinating and authorizing the provision of appropriate social support services. Overall, the contract must implement a system that coordinates care and creates linkages with organizations not providing covered services, such as social service agencies, federal agencies, and consumer, civic and religious organizations.
- Minnesota: Case Management includes using a method for coordinating enrollee medical needs with social service needs.
- Tennessee: Care coordination includes identifying needs and facilitating access to social support services relating to housing, transportation, income assistance, food security and nutrition, employment and social support.
- Wisconsin: A social service coordinator is required to be part of the ICT and is responsible for conducting assessments. The HRA must include an exploration around the member's housing and finances, and preferences for educational and vocational activities, including supported employment.

MLTSS contract supplementing FIDE SNP: SDOH Provisions without Reference to Dually Eligible Beneficiaries

- Arizona: Case managers must facilitate access to non-ALTCS services available in the community, assist members to identify their independent living goals and provide them

with information about local resources that may help them transition to greater self-sufficiency in areas of housing, education and employment. There also needs to be a staff person designated as the expert on housing, education and employment issues and resources in the service area.

- Florida: Case managers must be trained on local resources for housing, education and employment services/programs that can help enrollees gain greater self-sufficiency. There also needs to be a staff person designated as the expert on housing, education and employment issues and resources in the service area.
- New Jersey: Integrated care management includes the identification of all social support services and assistance needed to meet identified needs of the enrollee, and the coordination of care actively linking the enrollee to providers, medical services, residential, social and other support services when needed, including housing and income assistance, to delay or prevent the need for institutional placement.
- Tennessee: The contractor shall use care coordination to identify social support services and assistance (e.g., housing or income assistance) that are necessary to meet identified needs and the care/support coordinator is responsible for assessing, identifying, addressing and facilitating access to those services.

9. Transitions of Care (TOC)

Many contracts specifically referenced requirements for supporting transitions of care between acute and non-acute settings and related discharge planning. Idaho and Tennessee require notification of admission and discharge from an emergency room, inpatient, or residential/rehabilitation setting. Some states addressed coordinating and tracking to ensure that necessary services/transitional care are in place for individuals transferring settings. Idaho specifically referenced services needed to avoid readmissions.

FIDE SNP TOC References to Dually Eligible Beneficiaries

- Florida: Vendor must provide care coordination for dual members and must include a long-term care case manager who will manage transitions and access members accessing the full range of medically necessary services across Medicaid and Medicare.
- Idaho: The health plan must develop protocols and procedures to ensure the plan and interdisciplinary care teams are notified of a member's admission to and discharge from an emergency room, inpatient, or residential and rehabilitation setting. The plan must provide comprehensive transitional care to prevent avoidable readmissions and ensure appropriate follow-up care that includes the care coordinator, ensuring the member receives appropriate and cost-effective medically necessary services.
- Massachusetts: Enrollees who are admitted to an institution must receive Interdisciplinary Discharge Planning that begins at the point of admission, involves the GSSC, any HCBS providers, and the enrollee (or their designated representative) to determine which discharge setting is appropriate to allow for the arranging of services

that will be needed upon discharge. There must also be protocols for tracking and coordinating enrollee transfers from one setting to another to ensure the continued provision of necessary services.

- Minnesota: Rehabilitation services must be provided following acute events to ensure smooth transitions and coordination of information between acute, subacute, rehabilitation, NFs, and HCBS settings.

10. Data/IT/Reporting

States varied on the data and IT requirements for their FIDE SNP programs. Massachusetts requires plans to have a single, CER that contains the enrollee's medical, functional and social status, including involvement in community agencies and documentation of contacts with family members/caregivers. Four states - Idaho, Florida, Minnesota and Tennessee - require annual or quarterly submission of reports related to care coordination. Of note, New Jersey requires health plans to collect data regarding the satisfaction of participating providers that includes questions around appeals processes, reimbursement methodologies, and care management assistance.

IT References to Dually Eligible Beneficiaries

- Massachusetts FIDE SNP: The contractor must maintain a single, centralized, comprehensive record with the enrollee's medical, functional and social status that is accessible by the PCP and all members of the Primary Care Team. The record must contain reports about the involvement of community agencies not part of the provider network and the documentation of contacts with family members and persons giving informal support.
- Idaho FIDE SNP: The contractor must submit an assessment and care coordination report on the number of enrollees with initial HRAs, care coordinator ratios, and the number of enrollees with ICPs and ICTs. As well, the HRA must be recorded in the centralized enrollee record.
- Minnesota FIDE SNP: The contractor must report on their care coordination and case management systems annually, including how care coordination is provided, who is providing the care coordination, a description of all care coordination screenings and tools, and any trainings of care coordinators.
- Tennessee FIDE SNP: The plan must submit annual HEDIS, CAPHS, and HOS data to TennCare and for D-SNP plans they must also submit MA Star Quality ratings and quarterly reports on dually eligible beneficiaries' coordination, seamless conversion, and D-SNP appeals and grievances.
- Wisconsin FIDE SNP: The health plan must monitor the quality of care management by collecting evidence regarding timeliness of risk assessments, whether adequate member-centered plans are created, revised and update as needed, and services are delivered in accordance with the type, scope, amount and frequency.

- Wisconsin FIDE SNP: The health plan must submit to the State, any reports it submits to CMS regarding SNPs or PACE.

MLTSS contract supplementing FIDE SNP: IT-specific Provisions without Reference to Dually Eligible Beneficiaries

- Florida: The plan must conduct quarterly case file audits and reviews of the consistency of enrollee assessments, along with reports that demonstrate case management monitor and evaluation (including level of care assessments, staff meeting training requirements, plan of care audits).
- New Jersey: The contractor must collect data regarding the satisfaction of participating providers that includes questions around appeals processes, reimbursement methodologies, and care management assistance.
- Tennessee: The plan must develop or purchase an EVV system for CHOICES HCBS members. All admission, discharge and transfer data from applicable hospitals must be made available to all PCPs. The plan is also responsible for service coordination reports, submitted either monthly or quarterly, on care coordination (including staffing, enrollment, assessments, and service initiation), support coordination, caseload and staffing ratio reports, and meeting the urgent needs of members during transition.

11. Stakeholders

Contracts reviewed had few, if any, requirements for stakeholder engagement specific to dually eligible beneficiaries and care coordination.

C. Capitated FAI

The three-way Financial Alignment Initiative (FAI) demonstration contracts between the state, CMS, and the participating Medicare-Medicaid Plans (MMPs) specify care coordination requirements. While the overall requirements are similar across all states, the details vary, with some contracts more prescriptive than others:[6]

1. Care Coordinator Qualifications

States and MMPs establish different qualifications for care coordinators, and often tie educational, clinical and training requirements to the specific risk levels and populations served. For example, in Massachusetts, MMP care coordinators for enrollees with complex clinical care

[6] Based on the Joshua M. Weiner et al., *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative*, (Waltham, MA: RTI International, 2017), https://innovation.cms.gov/Files/reports/fai-carecoordination-issuebrief.pdf; Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment Access Commission (MACPAC), *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (2018), https://www.macpac.gov/wp-content/uploads/2017/01/Jan18_MedPAC_MACPAC_DualsDataBook.pdf; and HMA reviews of two additional FAI contracts not reviewed by RTI.

needs must be registered nurses or other licensed professionals trained in clinical care management, whereas MMPs may establish their own qualifications for other care coordinators. In Illinois, MMPs must hire "SNFists" – clinicians specializing in care management for nursing facility residents --who work alongside the care coordinator to meet the needs for enrollees living in nursing facilities.[7]

2. Scope of MMP Care Coordination

The capitated FAI program, described in the contracts, broadens the scope of the typical services being coordinated by managed care organizations beyond medical care to include behavioral health, LTSS, sometimes social supports and both covered and non-covered services.[8]

3. Family/Caregiver Involvement

All states' FAI contracts call for involving the enrollee's family and other caregivers in care coordination, "as appropriate" or "in accordance with the enrollee's needs or preference." The contracts call for family and other caregivers' role in the following: the HRA process (e.g., including assessment of caregiver status and capabilities); development of the ICP; membership in the ICT; and ongoing communication with the care coordinator. The contracts also include the federally-defined "enrollee rights" that require the MMPs to guarantee that enrollees "Be encouraged to involve caregivers or family members in treatment discussions and decisions."

4. Subcontractor and Function

A couple of states require MMPs to contract out some care coordination services to other entities. For example, Ohio MMPs must contract with Area Agencies on Aging for members aged 60 and older; Massachusetts MMPs contract with community-based organizations for long-term supports. Most states, however, appear to give MMPs flexibility to directly employ or contract out for at least certain aspects of care coordination.[9]

5. Health Risk Assessment (HRA)

All contracts require that MMPs perform an HRA including specified domains (e.g., medical, psychosocial, functional, LTSS, behavioral health, unmet social needs), but generally allow MMPs to develop their own assessment tools. Exceptions include the New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) contact, that requires MMPs to use the "It's All About Me" (IAM) tool, a person-centered assessment that describes the functional status, needs and wishes of a person with IDD across 24 domains and determines a recommended list of actions based on the person's current status.[10]

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[7] Weiner et al., *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans*
[8] Ibid.
[9] Ibid.
[10] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid (CMS), *Contract Between United States Department of Health and Human Services, Centers for Medicare & Medicaid*

- Some states require an initial health screen that, combined with predictive modeling and other data, determines the need, type, and timing of a more comprehensive HRA.
- The contracts define time frames (typically up to 90 days from enrollment) for completion of the HRA, with some variation by risk level and across states; e.g., within 15 days of enrollment for the highest risk group and 75 days for other tiers in Ohio. With early challenges completing HRAs, some states relaxed the timeframe requirements and the processes for assessments or reassessments (e.g., New York FIDA, Massachusetts).[11]
- Reassessments are generally required at least annually, plus after a hospital discharge or change in health status, or more frequently for high-risk enrollees (e.g., Rhode Island requires reassessments at least every 90 days for enrollees eligible for LTSS or deemed high-risk).
- Some states require in-person assessments (e.g., Ohio, Massachusetts) and specify clinical qualifications (e.g., RN in New York) for the person administering the HRA for higher-risk enrollees.

6. Individualized Care Plan (ICP)

FAI enrollees must have ICPs, with the exact content and format varying by state and enrollee risk level. The ICPs are based largely on the HRA, usually developed by the interdisciplinary care team and led by the care coordinator.

- The contracts require incorporating the enrollee's or family/caregiver/designee's input, preferences, and measurable goals, with a few states specifically calling for a "person-centered" approach (California, Michigan, New York-IDD) or culture and language appropriate ICPs (South Carolina, Rhode Island).
- Timeframes for completion of ICPs are based either on days since enrollment (typically 90 days- Illinois, South Carolina, Michigan), or days since HRA completion (e.g., 15 days in Ohio).
- Rhode Island's contract is especially detailed in ICP specifications for different populations; e.g., for community-based LTSS and high-risk enrollees, the ICP must document: enrollee needs identified by the ICT and HRA, including medical, behavioral health, LTSS, Health Home services, and other critical needs (e.g. legal or housing), covered services and Carved-Out Services; enrollee-specific short and long-term goals; amount, duration, and scope of services to be provided including care management and informal supports; plans for care transitions; expected outcomes, measures, and timelines; barriers to service delivery and strategies to overcome them; and other

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Services in Partnership with The State of New York, Department of Health, and <Plan Name>, (CMS: 2016). https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/NY%20FIDA%20IDD%20Three-Way%20Contract%202016.pdf

[11] Weiner et al., *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans*

specified components. For LTSS enrollees, a LTSS Care Plan focusing on LTSS goals, services and supports, risk mitigation, and a 24/7 back-up plan is part of the ICP.

7. Interdisciplinary Care Team (ICT)

All MMP contracts require that enrollees have access to an ICT, essentially to develop, implement and maintain an enrollee's ICP.

- The core interdisciplinary care team members are the care coordinator and primary care provider (PCP), with some states (Ohio, Rhode Island, Michigan) specifying that the enrollee him/herself is a core member – thereby emphasizing the person-centeredness of the team. Additional members may include specialists, social workers, behavioral health providers, long-term supports coordinators, family/caregivers, and others based on the enrollee's needs and preferences.
- Unique provisions include:
    - Michigan's contract specifies that the enrollee may choose which interdisciplinary member will be the enrollee's primary contact.
    - New York's contracts (both FIDA and FIDA-IDD) establish that the interdisciplinary care team's decisions serve as service authorizations (subject to licensure/scope of practice).

8. Social Determinants of Health (SDOH)

SDOH are often included in the required domains of the HRA. Massachusetts' contract is most explicit in housing and home environment factors that must be included in the HRA:

- Considerations specific to homeless enrollees;
- Risk of homelessness;
- Home accessibility requirements;
- Housing preferences, including who the Enrollee lives with;
- Methods for heating and cooling Enrollee's home;
- Home safety; and
- Any services provided in a residential setting;

Most contracts require care coordination to include assistance with accessing transportation, housing, and/or other supports. Rhode Island's contract specifically requires the MMP to "assist Enrollees to access necessary housing arrangements and agrees to collaborate with all State and federal housing authorities to accomplish access."

9. Transitions of Care (TOC)

All states require coordination when the enrollee transitions across settings, although the language differs across contracts. Many describe involvement in discharge planning when an enrollee leaves a hospital or institution and suggest that a hospital discharge planner can be included as appropriate on the ICT (e.g., California, Michigan).

- Rhode Island's contract is most detailed on defining the various types of transitions across care settings (nursing facility to community, community to hospital, etc.) and in setting standards for transitional care management:
    - 2.5.6.10.2. The Contractor must adopt or modify existing transition models or develop its own transition model to ensure effective transitions and continuity of care when Enrollees move between levels of care.
    - 2.5.6.10.3. The Contractor shall have transitional Care Management and support during transitions across care settings twenty-four (24) hours a day, seven (7) days a week.
    - 2.5.6.10.3.1. The transitional Care Management program must provide onsite visits with the LCM and/or Care Coordinator upon discharge from hospitals, nursing facilities, or other institutional settings.
    - 2.6.5 The ICP must be modified, if necessary, within five (5) Days after a hospitalization.
    - 2.6.6 The Wellness Plan must be modified, if necessary, within five (5) Days of a hospitalization.
    - 2.6.3.5.5. The LCM or Care Manager will hold in-person or telephonic ICT meeting(s) on an as needed basis, including any time an Enrollee experiences a significant change in condition (e.g. hospitalization or loss of caregiver) and qualifies for ICM.

10. Data/IT/Reporting:

The general requirements for establishing care management information systems for obtaining and tracking data relevant to care coordination, and for sharing data among ICT members are the same for participating states,[12] though the contract language varied.

- New York contracts detail the data to which the ICT members must have access. The FIDA-IDD Plans, for example, are required to keep a Comprehensive Health Record, available to all ICT members, that contains a summary of emergency care and other inpatient or long-term care services; items and services furnished by Network and Out-Of-Network Providers; current and past Assessments, Reassessments, LPs, and any file notes that include the Participant's response to treatment; laboratory, radiological and other diagnostic test reports; medication records and, if applicable, skilled nursing facility/nursing facility to hospital transfer forms; hospital discharge summaries, if applicable; reports of contact with informal support (for example, caregiver, legal guardian, or next of kin); physician orders; discharge summary, if applicable; advance directives, if applicable; and a signed release permitting disclosure of personal information.[13] The New York FIDA Plans are "encouraged" to join regional health

[12] Weiner et al., *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans*
[13] CMS, *Contract Between United States Department of Health and Human Services*

information networks or qualified health information technology (HIT) entities for data exchange and to share information with all Providers participating in a Person- Centered Service Plan (PCSP).[14]

- South Carolina modified its electronic Medicaid home and community-based services waiver case management and service authorization system, called Phoenix, to meet the demonstration's needs, and requires MMPs to use Phoenix to document all assessments, ICPs, provider information, caregiver support systems, waiver case management, and quality assurance activities for FAI enrollees. ICT members can access Phoenix to read or input notes on their enrollees.[15]

11. Stakeholders

While stakeholder engagement is not a major component of the FAI contracts, the NY FIDA-IDD contract states, "The FIDA-IDD Plan must solicit input from Participants and other stakeholders to help develop strategies to increase motivation for enhanced independent and healthy living."[16]

[14] Ibid.
[15] Weiner et al., *Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans*
[16] CMS, *Contract Between United States Department of Health and Human Services*