BRIEF

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

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

Long-Term Services and Supports (LTSS) include a wide range of activities designed to assist older adults and people with disabilities in managing daily activities in institutional and community-based settings. Given anticipated growth in the population eligible for LTSS, states continue to explore ways to improve service delivery and meet individuals' preferences to live in their homes and communities—all while remaining mindful of costs.[1] Increasingly, states are looking to health plans to manage LTSS administration and delivery. This opportunity presents challenges for plans that are unfamiliar with the evolving home and community-based services (HCBS) landscape.

Medicaid-covered HCBS activities vary by state and may include home cleaning and management tasks, personal care, meals, transportation, and more. To ensure that enrollees have access to the full range of Medicaid-covered services, health plans must contract with providers of whichever HCBS activities are covered in their enrollees' states of residency.

Provider contracting, however, is just one of many factors a health plan can evaluate as it looks to support the growing LTSS population. This brief provides key considerations for understanding LTSS program priorities for the state(s) in which the plan operates, assessing plan enrollees' LTSS needs, and ensuring the delivery of person-centered care.

Key Considerations

Understand the State's Priorities

As of 2023, 24 states operate Managed Long-Term Services and Supports (MLTSS),[2] each with its own unique system based on federal regulations, state goals, and strategies. Any state that pursues MLTSS must build its system according to state-specific priorities. A state may carve out from its managed care organizations' (MCOs) contracts, for example, institutional care; specific services like behavioral health, pharmacy, and dental services; or HCBS for individuals with intellectual and developmental disabilities.[3] It is important for health plans to understand the individual state priorities and policies (e.g., the use of in-lieu-of services, value-added services, the role of Electronic Visit Verification) for each state in which they operate.

Understand Implications for Dually Eligible Enrollees

In 2024, an estimated 12.8 million people are dually enrolled in Medicare and Medicaid.[4] Compared to those enrolled in Medicare alone, dually eligible individuals often have more complex medical and social needs and, as a result, experience poorer health outcomes.[5] Dual enrollment in Medicare and Medicaid—two programs that were not designed to work together—can result in a fragmented

experience and may exacerbate negative health outcomes among dually eligible enrollees.[6] To better serve dually eligible enrollees, health plans can:

- Identify which enrollees are dually eligible;
- Understand what coverage the health plan's contract with the state Medicaid agency requires for dually eligible individuals;
- Develop communication and engagement strategies to help enrollees navigate Medicare-Medicaid systems;
- Ensure providers understand the needs of the dually eligible population; and
- Understand the state's priorities in Medicare-Medicaid integration. For a brief overview of the different Medicare-Medicaid programs, see the *Key Programs Serving Dual Eligibles Guidebook*.

Understand the Populations You Serve

The LTSS needs of enrollees vary depending on age, physical, intellectual and developmental disabilities, mental health condition, health-related social needs (HRSNs), and social determinants of health (SDOH). HRSNs account for such factors as socioeconomic status, education, neighborhood, physical environment, employment, and social support networks; SDOH addresses the conditions in which people live their lives, which include such factors as racism and institutional biases.[7] As of 2024, Dual Eligible Special Needs Plans (D-SNPs) must include one or more health risk assessment (HRA) questions that address key HRSNs: housing, food security, and transportation.[8] These questions support health plan efforts to account for enrollees' unmet social needs as part of developing care plans that connect enrollees to LTSS.

Individual needs also depend on the types of family or informal caregiver supports available to enrollees. The Family Caregiving Advisory Council, established by the Recognize, Assist, Include, Support, & Engage (RAISE) Caregivers Act of 2017 (Public Law 115-119), published the *RAISE Family Caregivers Act Report*, which outlines recommendations for improving the experiences of the nation's family caregivers. One of the recommendations includes "engag[ing] family caregivers through the use of evidence supported and culturally sensitive family caregiver assessments to determine the willingness, ability, and needs of family caregivers to provide support."[9] In addition to unmet social needs, the assessment process can help plans stratify enrollees by risk levels to identify barriers to services and more efficiently coordinate care.

An enrollee's race or ethnicity, gender, and cultural and linguistic background also influence the types of supports that will best serve them. Research indicates that Black, Indigenous, and People of Color and individuals with limited English proficiency often experience lower quality of health care and poorer health outcomes.[10] The increasing diversity in plan enrollment highlights the need for plans to understand and address the cultural and linguistic needs of the populations they serve.[11] Health plans can take several steps—for example, they can:

- Hire and recruit multilingual staff and providers with a variety of cultural and social perspectives;
- Educate staff about enrollee diversity; and
- Develop a language access plan that outlines steps to reduce disparities in service access between native and non-native English speakers.

Understand the Local Provider Environment

Health plans benefit from understanding the local provider environment, which can greatly affect enrollees' access to care. Research suggests that providers may be less likely to accept new Medicaid patients than new patients insured by other payers.[12] In 2017, Kaiser Family Foundation surveyed Medicaid managed care plans on strategies to address challenges facing provider networks. Plans reported on the use of recruitment and retention strategies, such as direct outreach to providers, financial incentives, automatic assignment of enrollees to primary care providers (PCPs), and prompt payment policies. Respondents also shared frustrations and barriers to recruiting PCPs versus specialty providers to their networks.[13] In June 2021, the Centers for Medicare & Medicaid Services (CMS) announced plans to introduce a series of technical assistance toolkits addressing key topics (e.g., behavioral health access, strategies for ensuring provider network adequacy) to assist states in complying with various managed care standards and regulations.

Create a Person-Centered Service Plan

States with Medicaid coverage for HCBS are required to develop individualized, person-centered service plans with enrollees; the role of the health plan in this process will vary depending on the state, its service planning timeline, and other requirements. Health plans should ensure they understand and can clearly document both the state's planning process and the plan's role within it.

Person-Centered Planning Resources

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

Person-Centered Planning

Person-centered planning enables health plans to provide tailored services that can help older enrollees or enrollees living with disabilities remain in the community.[14] It endeavors to preserve enrollee autonomy and engage the sustainability of their natural supports (e.g., family members, informal caregivers) to determine the enrollee's LTSS needs. A key component involves considering how an individual's demographics and cultural identity inform their care needs.

Review Functional Assessment Tool and Requirements for States in Which Your Plan Operates

Health plans should ensure that their contracts with state Medicaid agencies clearly describe assessment responsibilities, timeframes, and reporting requirements, as well as specific approved assessment protocols. The number of enrollees that require assessment also may vary by enrollment policies in each state. Many require a functional assessment for Medicaid enrollees who need HCBS.

Assessment completion requirements—that is, whether the assessment may be completed by state employees, the health plan, or a third party—also vary by state. Relatedly, some states may mandate that health plans conduct a comprehensive health assessment while another entity conducts the functional assessment. If the functional assessment is conducted outside the health plan, health plan staff will often have access to the results. For a brief overview of the types of functional assessment processes states use, see this overview from The SCAN Foundation.

Assessing HRSN and SDOH. Research indicates that addressing SDOH is vital for improving health outcomes and reducing health disparities.[15] To address these factors, some states require MCOs to conduct assessments and connect enrollees to social supports as part of their MCO contract.[16] Starting in 2024, D-SNPs must include one or more questions addressing SDOH in HRAs.[17]

Remind enrollees of reassessment requirements. Failure to complete reassessments on time can affect an enrollee's Medicaid eligibility. While the same entity that determined initial functional eligibility is likely to perform subsequent reassessments, health plans can play an active role by reminding enrollees of upcoming reassessment periods. Plans also can collaborate with their state(s) to inform enrollees about state-mandated reassessment processes and timelines, which will help ensure that enrollees do not experience a gap in Medicaid coverage and needed services.

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

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