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Exclusively Aligned Enrollment 101: Considerations for States Interested in Leveraging D-SNPs to Integrate Medicare and Medicaid Benefits

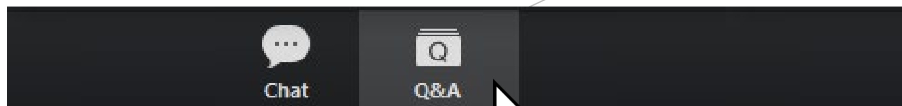
May 4, 2022

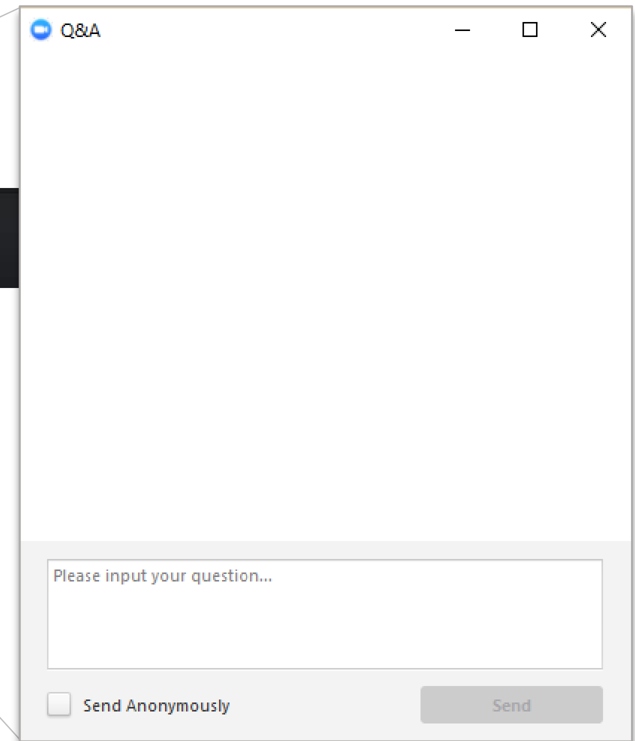
2:30-3:30 pm Eastern Time

The Integrated Care Resource Center, an initiative of the Centers for Medicare & Medicaid Services' Medicare-Medicaid Coordination Office, provides technical assistance for states coordinated by Mathematica and the Center for Health Care Strategies.

Questions?

To submit a question online, please click the Q&A icon located at the bottom of the screen.





Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.

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Agenda

- Welcome and Introductions
- Background: Using D-SNPs to Integrate Care for Dually Eligible Individuals
- Introduction to Exclusively Aligned Enrollment (EAE)
  - What is EAE?
  - Why implement EAE?
  - Which states are currently using EAE?
- Key Considerations in Designing and Implementing EAE
- Beneficiary, Provider, and Plan Engagement
- Idaho's Experience with EAE
- Questions and Discussion

Presenters

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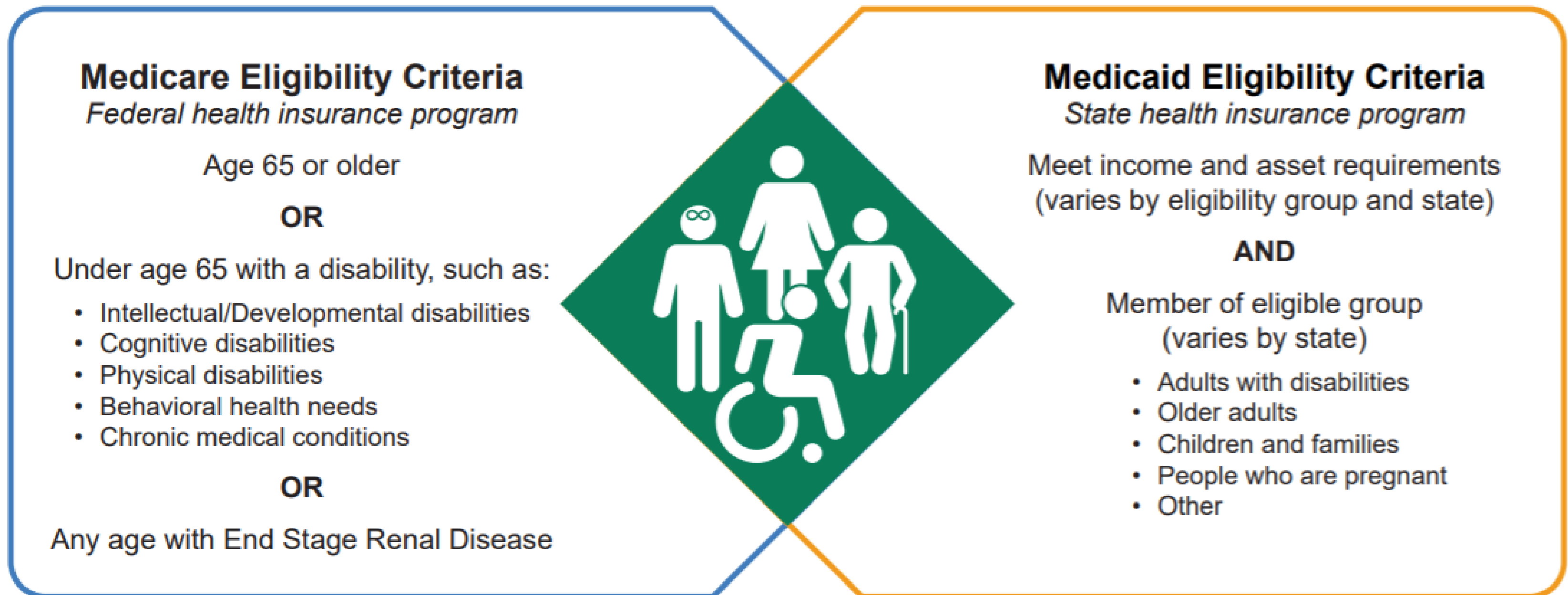
Background: Using D-SNPs to Integrate Medicare and Medicaid Benefits for Dually Eligible Individuals

Dually Eligible Individuals Qualify for Both Medicare and Medicaid



There are 12 million dually eligible individuals in the United States.

Source: Integrated Care Resource Center (ICRC) fact sheet, "Dually Eligible Individuals: The Basics," March 2021. Available at https://www.integratedcareresourcecenter.com/resource/dually-eligible-individuals-basics

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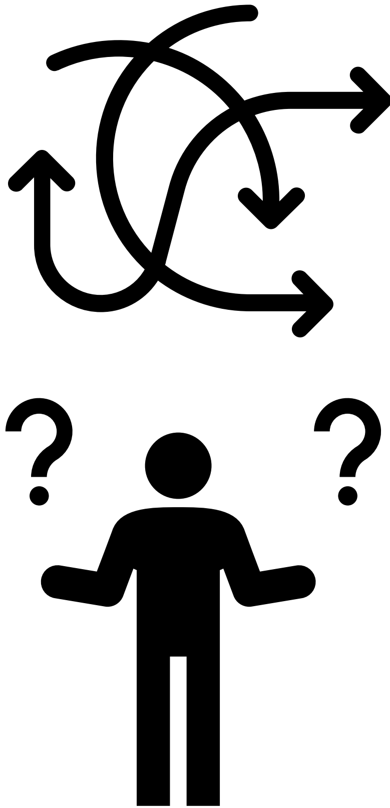
Navigating Two Health Insurance Systems is Complex



- **Service coverage:** Medicare and Medicaid have different coverage rules - some distinct from each other, others overlapping.
- **Provider availability:** It can sometimes be challenging to find providers who accept both Medicare and Medicaid.
- **Administrative processes:** Beneficiaries may not understand the distinct enrollment, appeals, and grievance processes for each program.

Dually Eligible Individuals Are a High-Need, High-Cost Population

70%
have been diagnosed with three or more chronic conditions, such as

- Diabetes
- Alzheimer's disease
- Heart disease
- Intellectual disabilities

41%
have a behavioral health disorder, such as

- Depression
- Bipolar Disorder
- Anxiety
- Schizophrenia

Over 40%
use long-term services and supports, such as

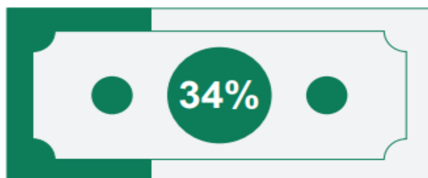
- Nursing facility services
- Home and community-based services

	MEDICARE		MEDICAID
Proportion of enrollees	19%		14%
Proportion of spending	34%		30%

MEDICARE

19%

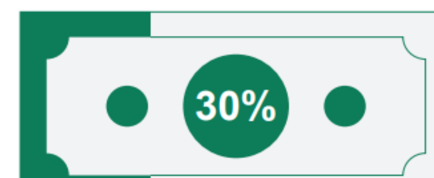
Proportion of enrollees



Proportion of spending

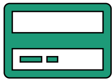
MEDICAID

14%

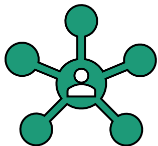


Source: Integrated Care Resource Center (ICRC) fact sheet, "Dually Eligible Individuals: The Basics," April 2022. Available at https://www.integratedcareresourcecenter.com/resource/dually-eligible-individuals-basics

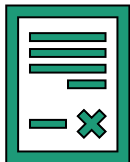
Using D-SNPs to Coordinate Care for Dually Eligible Individuals



- D-SNPs are Medicare Advantage (MA) plans that enroll only dually eligible individuals.
- All D-SNPs must at least coordinate Medicaid benefits for their dually eligible members.



- All D-SNPs must also have a Model of Care that:
  - Describes the dually eligible populations to be served,
  - Explains how the D-SNP will coordinate care for its members,
  - Describes the plan's specialized provider network and interdisciplinary care team protocols, and
  - Illustrates how the plan will measure and improve quality and performance over time.



- To operate in a state, a D-SNP must hold a contract with the state Medicaid agency, in addition to a contract with the Centers for Medicare & Medicaid Services (CMS).
  - States can leverage their contracts with D-SNPs to require D-SNPs to take additional steps to integrate Medicare and Medicaid benefits, such as:
    - Requiring D-SNPs to cover Medicaid benefits through the D-SNP or through an affiliated Medicaid managed care plan
    - Requiring state-specific care coordination activities
    - Requiring D-SNPs to operate with exclusively aligned enrollment

Levels of D-SNP Integration

Coordination-Only D-SNPs

- Coordinates Medicaid benefits for plan members (for example, by connecting members with Medicaid benefits and/or assisting with Medicaid appeal or grievance processes)
- Notify the state or the state's designee of **hospital and skilled nursing facility admissions** for a group of designated high-risk enrollees
- May be capitated to cover some Medicaid benefits

Highly Integrated D-SNPs (HIDE SNPs)

- D-SNP's parent company is **capitated by the state to cover Medicaid behavioral health and/or LTSS** benefits through the D-SNP or an affiliated Medicaid managed care plan
- **NEW: Starting in 2025, each HIDE SNP's capitated contract with the state for coverage of Medicaid benefits must apply to the entire service area for the D-SNP**

Fully Integrated D-SNPs (FIDE SNPs)

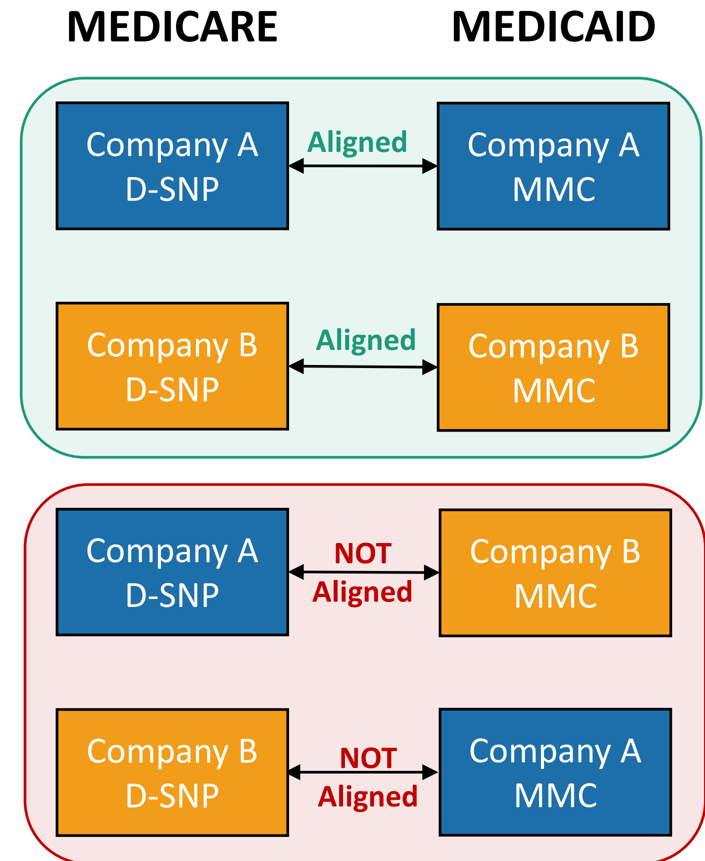
- The **same legal entity** operating the D-SNP is **capitated by the state to cover LTSS**
- **Covers other Medicaid benefits** (including behavioral health) as long as the state does not decide to carve those benefits out of the capitated contract
- Has **coordinated care delivery** and coordinates or integrates certain administrative functions
- **NEW: Starting in 2025, FIDE SNPs must operate with exclusively aligned enrollment and cover Medicaid home health; medical supplies, equipment and appliances; and behavioral health services through a capitated contract with the state Medicaid agency**

Sources: CMS. "Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for State Medicaid Agency Contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) for Contract Year 2021." November 14, 2019. Available at: https://www.Medicaid.gov/federal-policy-guidance/downloads/cib111419-2.pdf
CMS. "Additional Guidance on CY 2021 Medicare-Medicaid Integration Requirements for Dual Eligible Special Needs Plans (D-SNPs)." January 17, 2020. Available at: https://www.cms.gov/files/document/cy2021dsnpsmedicaremedicaidintegrationrequirements.pdf
CMS. "Medicare Program: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs." April 29, 2022. Available at: https://www.federalregister.gov/public-inspection/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

Introduction to Exclusively Aligned Enrollment (EAE)

What is Aligned Enrollment?

Aligned Enrollment occurs when a beneficiary is enrolled in a D-SNP and affiliated Medicaid Managed Care (MMC) plan offered by the same parent company in the same geographic area.



For more information, see: E. Weir Lakhmani and A. Kruse. "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment." ICRC, April 2018. Available at: https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Aligning_Enrollment.pdf

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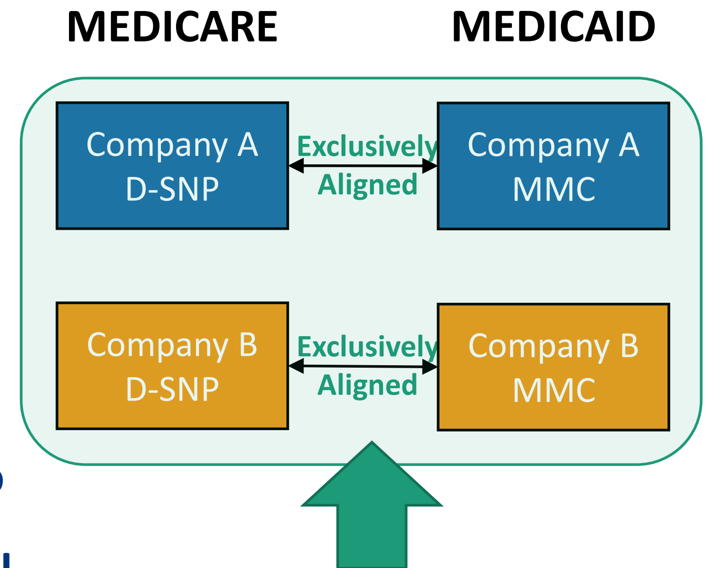
What is Exclusively Aligned Enrollment?

***Exclusively* aligned enrollment** occurs when the state contract limits enrollment in the D-SNP to full-benefit dually eligible individuals who receive their Medicaid benefits from the D-SNP or an affiliated Medicaid Managed Care plan offered by the same parent company as the D-SNP.



State only allows Company A D-SNP to enroll individuals who are also enrolled in Company A MMC, and Company B D-SNP to enroll individuals in Company B MMC.

For more information, see: E. Weir Lakhmani and A. Kruse. "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment." ICRC, April 2018. Available at: https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Aligning_Enrollment.pdf

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What Are Applicable Integrated Plans (AIPs)?

- **In 2022, Applicable Integrated Plans (AIPs)** are FIDE SNPs and HIDE SNPs that operate with exclusively aligned enrollment.
- These plans are required by CMS to have integrated plan-level appeals and grievance processes.
- As a result of the CY2023 Medicare Advantage and Part D final rule released by CMS on April 29:
  - All FIDE SNPs must have EAE starting in 2025
    - Therefore, starting in 2025, all FIDE SNPs will be AIPs
  - The definition of AIP is being revised (starting in 2023) to include coordination-only D-SNPs that operate with EAE and cover certain Medicaid benefits (through the D-SNP or through an affiliated Medicaid managed care plan).

Source:
CMS. "Medicare Program: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs." April 29, 2022. Available at: https://www.federalregister.gov/public-inspection/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

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Why Implement EAE?

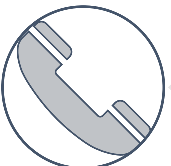
EAE Facilitates Integrated Beneficiary and Provider Experiences

Single ID card for both Medicare and Medicaid benefits

Comprehensive, coordinated benefits package and delivery of benefits with integrated benefit determinations, appeals, and grievance systems

Fully integrated enrollee materials, including single Medicare/Medicaid plan enrollment documents and Summary of Benefits information

More seamless care coordination with all benefits covered under same parent organization

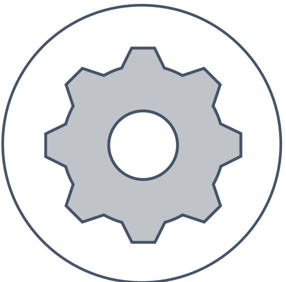


One customer service number and ideally, customer service staff who are specifically trained on EAE plan benefits/systems

EAE Benefits for Plans + State and Federal Payers

One parent company financially responsible for all (or substantially all) Medicare and Medicaid benefits – no incentive to cost-shift across programs

Single parent company possesses **all data on beneficiary's service utilization and care experience** – facilitates better coordination and identification of opportunities to improve care/save money + evaluation of data on beneficiaries' experiences



Fully integrated benefit structure, care coordination, and enrollee materials are easier for plans to design and deliver than materials and processes that must cater to multiple sets of beneficiary circumstances

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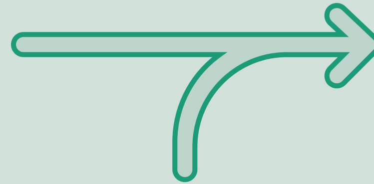
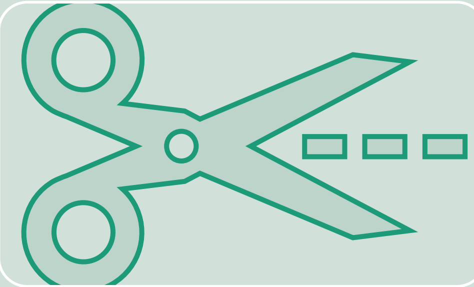
Key Considerations in Designing and Implementing EAE

Models for Achieving EAE

Direct capitation



Aligned Medicare and Medicaid plans



Separate D-SNP plan benefit packages (PBPs) for “aligned” and “unaligned” enrollees

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Key Considerations

Existing state landscape

- Does the state already have D-SNPs? How many enrollees do they have? Are any of those enrollees already “aligned?”
- Does the state enroll dually eligible individuals in managed care for Medicaid benefits? If not, does the state have any Medicaid managed care programs for other populations?
  - **In states with Medicaid managed care (MMC) programs:**
    - Do the parent companies offering D-SNPs align with the parent companies offering Medicaid managed care plans?
    - Are any Medicaid benefits currently carved out of managed care coverage? Are those carve-outs legislatively mandated?
  - **States without MMC programs for dually eligible individuals that wish to directly capitate D-SNPs to cover Medicaid benefits for their enrollees must consider their Medicaid managed care authority options:**
    - 1915(a) or 1932(a) for voluntary enrollment
    - 1915(b) or 1115 for mandatory enrollment

Key Considerations *(continued 2)*

- **Medicaid enrollment typically follows Medicare enrollment**
  - Cannot "force" a beneficiary into a managed care plan for Medicare benefits – CMS requires that they have the ability to select FFS Medicare
  - Medicaid rules allow states to require a beneficiary to receive benefits through a managed care plan and 'lock' the beneficiary into that plan for a period of time
- While it could be possible for a state to limit D-SNP eligibility to individuals who are already enrolled in an affiliated Medicaid managed care plan through the same parent company as the D-SNP, no states have used this model yet.
  - This model could reduce the number of beneficiaries who opt into the integrated D-SNP, as it would require the person to already be enrolled in the affiliated Medicaid plan, rather than simply moving the person into the affiliated Medicaid plan when they elect to enroll in the D-SNP.

Key Considerations *(continued 3)*

- **Assemble dedicated team from a variety of key state Medicaid agency divisions/ departments**
  - Policy, eligibility, IT, contracting/legal, communications/ marketing, customer service, provider relations, clinical/quality
- **Multiple D-SNP divisions should be involved also**
  - Enrollment, care management, customer service, IT/data/reporting, utilization management, appeals and grievances, etc.
- **Other entities involved in building & executing EAE**
  - CMS
  - D-SNPs
  - State enrollment broker, if applicable
  - Medicaid managed care plans

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Beneficiary, Provider, and Plan Engagement

- **Beneficiaries and beneficiary advocacy organizations**
  - Potential concerns about freedom of choice
  - Potential support for better coordination/simplification of benefits, materials, etc.
- **Providers**
  - Potential concerns about plan contracts/changes in existing processes/reductions in payment
  - Potential support for simplification of payment mechanisms
- **Plans**
  - Potential "winners" and "losers" if current landscape includes both D-SNPs and MMC plans when parent companies do not align
- **Governor/Legislators**
  - In some states, making substantial changes to Medicaid managed care programs (or making changes that could have budgetary impact for Medicaid) requires gubernatorial support and legislative approval
  - Potential to limit/prevent cost shifting to Medicaid

Educating Dually Eligible Individuals About EAE

- **Explaining benefits of EAE and EAE enrollment options**
  - EAE training and reference materials for State Health Insurance Assistance Program (SHIP) and community counselors
  - State and plan websites, fact sheets, FAQs
  - Medicaid benefit notices and/or managed care enrollment packets
- **Explaining implications of EAE for Medicaid coverage**
  - Integrated beneficiary enrollment forms (NJ, MA, MN)
  - Plan "welcome" materials, Summary of Benefits documents or other enrollee materials
  - Website and marketing materials
  - Outbound "welcome" or enrollment verification calls

Idaho's Experience with EAE

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Idaho Duals' Programs and Exclusively Aligned Enrollment

Alexandra Fernandez, Bureau Chief

Chris Barrott, Program Manager

Bureau of Long Term Care

IDAHO DEPARTMENT OF HEALTH & WELFARE

Idaho's FIDE-SNP History

- In 2011, the Idaho legislature directed Idaho Medicaid to develop a managed care delivery system for duals
- Idaho intended to participate in the Financial Alignment Demonstration in 2014 – however, at the last moment, two of our three Health Plans declined to participate.
- With only one remaining Plan, CMS would not permit us to apply for the demonstration. In order to still fulfill our legislative mandate, we designed and built the Medicare Medicaid Coordinated Plan (MMCP) that constitutes a FIDESNP. Idaho Medicaid does not enter into agreements for any other type of DSNP.
- Our first Plan launched in June 2014. A second participating plan joined the market in January 2018.

EAE Implementation

- Idaho's FIDE-SNP has had EAE since inception. The fundamental principle of our program design is that the FIDE-SNP operated indistinguishable from its MLTSS components.
- Aspects of Idaho's EAE platform
  - The state does not initiate enrollment into the MMCP.
  - The Plan is responsible for submitting an enrollment record to the state's MMIS **only** ***after*** successful enrollment via CMS into the FIDE-SNP
  - The enrollment activities between the state and Plan are automated via an 834 EDI file exchange.
  - Enrollment into the FIDE-SNP is considered complete by the state when the participating Plan has confirmed enrollment for both the Medicare and Medicaid.
  - Enrollment can only occur **prospectively** and is effective the first day of the calendar month following **successful** enrollment actions by the Plan.

EAE Benefits

- Members and providers perceive one singular program rather than two distinct, but related components.
- Coordination of Benefits (COB) claims submission and processing is more straightforward for service providers with EAE.
- The state does not have to independently manage enrollment activities. The responsibility for enrollment rests on the Plans.

EAE Challenges

- Prospective enrollment has caused misaligned coverage months for some members.
  - Example: Participant calls Medicare directly on April 30th and enrolls in Plan A's FIDE-SNP. Plan A receives the enrollment record the next day, May 1st. The Plan submits an ADD request to the state's MMIS on the 834 file on May 1st, but because enrollment is prospective only, that member's coverage cannot be effective until June 1st. For this misaligned month, Plan A must manage the member's Medicare coverage, and fee-for-service Medicaid would manage the member's Medicaid coverage.
- Participating Plans don't love misaligned coverage months

EAE Challenges (continued)

- Why doesn't the state consider retroactive enrollment?
  - Based on stakeholder feedback, it would be more complicated for providers and billing activities
  - Retroactive enrollment would be costly and would disrupt capitation payment activity for our various managed care vendors and brokerage contracts.

Considerations for Other States

- Find opportunities for your Plan to do the work for you
  - Idaho's system error rate went from 79% to under 3% by making the Plan responsible for its own activities. We also began imposing invoice reductions for enrollment file errors, incentivizing the Plan to better manage enrollment activities and reconcile file transactions.
- Weigh costs versus benefits of both the implementation strategy and maintenance strategy.
  - In Idaho's case, we recognize that misaligned enrollment months are not optimal. However, after assessing the volume of this occurrence in relative comparison to the cost and effort to manage retroactive enrollment, we have elected to take this risk by keeping prospective enrollment.

Contact Information

Please feel free to reach out to us for additional information!

- Chris Barrott: Chris.Barrott@dhw.Idaho.gov
- Ali Fernández: Alexandra.Fernandez@dhw.Idaho.gov

Q&A

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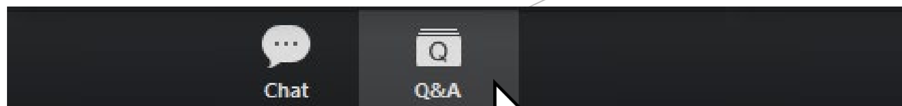

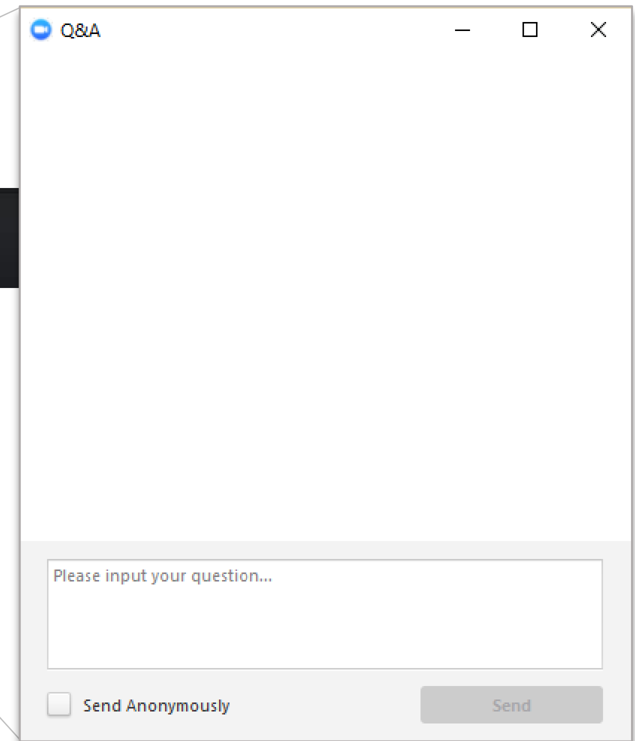

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About ICRC

- Established by CMS to advance integrated care models for dually eligible individuals
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica and the Center for Health Care Strategies
- Visit http://www.integratedcareresourcecenter.com to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send other ICRC questions to: integratedcareresourcecenter@chcs.org

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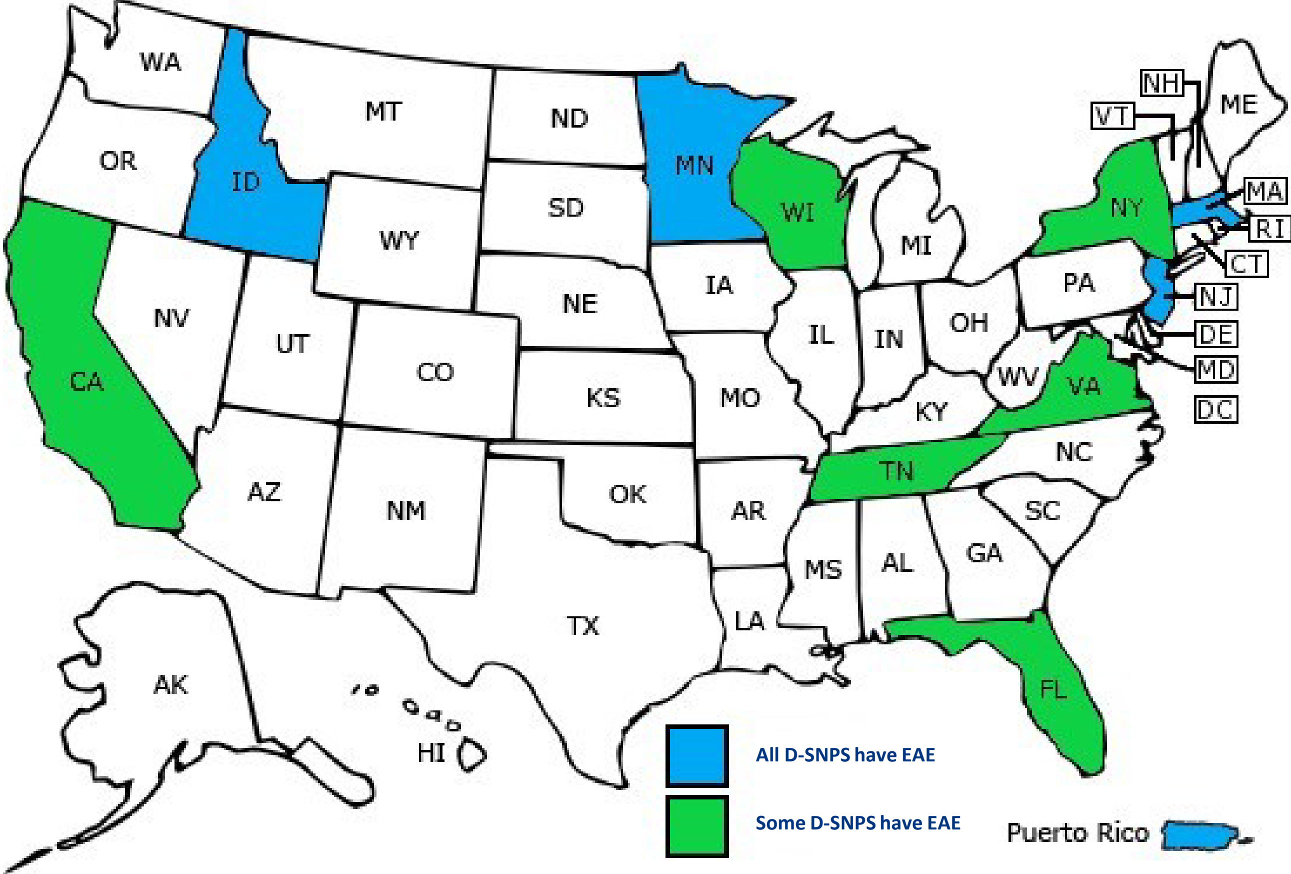
Appendix:
Which States Are Currently Using EAE?

States Using EAE, 2022



Sources: CMS Special Needs Plan (SNP) Data: [Special Needs Plan (SNP) Data | CMS] & CMS Integration Status for Contract Year 2022: [smacdsnpintegrationstatusesdatacy2022.xlsx (live.com)]

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Number of Exclusively Aligned Enrollees in AIP D-SNPs by State

State	Total Enrollment in AIP D-SNPs as of March 2022	% of FBDE Individuals in the State Enrolled in an AIP D-SNP
California	14,833	1.1%
Florida	29,588	7.3%
Idaho	11,809	41.8%
Massachusetts	63,799	22.2%
Minnesota	51,120	42.2%
New Jersey	70,185	35.9%
New York	35,875	4.6%
Puerto Rico	286, 679	100%
Tennessee	1,764	1.2%
Virginia	20,737	15.9%
Wisconsin	2,620	1.7%

Data sources: CMS MMCO Enrollment Snapshots, Quarterly Release (06/2015 - 3/2020), https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics; Enrollment data from March 2022. The payment reflects enrollments accepted through February 4, 2022. Centers for Medicare & Medicaid Services (CMS) Special Needs Plan (SNP) Comprehensive Monthly Enrollment Report, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data. AIP contract information provided by the CMS Medicare-Medicaid Coordination Office (MMCO). Integration Status information is from the Integration Status for Contract Year 2022 D-SNPs, available at: https://www.cms.gov/files/document/smacdsnpintegrationstatusesdatacy2022.xlsx.