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Integrated Care Programs for Dually Eligible Individuals in the Era of COVID-19: Response Efforts and Policy Recommendations

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Contents

Executive Summary

COVID-19 continues to pose unprecedented challenges for the health care system. As the pandemic has unfolded, it has become evident that individuals who are dually eligible for Medicare and Medicaid are some of the country's most at-risk and vulnerable populations. With this cohort of individuals largely receiving care in uncoordinated, fragmented systems, it is critical to identify opportunities to improve and expand programs and policies to best support this population during public health emergencies such as COVID-19 and in the future. While there has been significant progress over the last decade in the number of dually eligible individuals receiving care through integrated care programs, only one of the 10 million full benefit dual eligibles are currently served in an integrated program. These programs offer aligned enrollment, care coordination, and incentives across payers and providers to support positive care outcomes. Integrated care programs include aligned Medicaid managed long-term services and supports programs and Dual Eligible Special Needs Plans (D-SNPs), Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), and Medicare-Medicaid Plans (MMPs) that operate as a part of the Financial Alignment Initiative (FAI) demonstrations.

This report, developed by Speire Healthcare Strategies and the Center for Health Care Strategies (CHCS) with support from Arnold Ventures, distills insights about COVID-19 response efforts from states that offer integrated programs and their health plans, and provides policy and programmatic recommendations.

Over the summer of 2020, Speire and CHCS conducted research on current response efforts within programs for dually eligible individuals.[1] Based on the information collected, the Speire and CHCS team developed a series of policy and programmatic recommendations for policymakers. Policy recommendations include suggestions to:

1. Increase alignment between Medicare and Medicaid;
2. Increase plans' flexibilities to meet member needs;
3. Pay family caregivers and support other efforts to expand the workforce;
4. Expand supplemental benefit offerings;
5. Improve communication and data sharing; and
6. Ensure fiduciary oversight.

The program recommendations include potential terms for state Medicaid agency contracts (SMACs) with D-SNPs and Medicaid managed care contracts.

Four areas of focus also emerged as critical to a successful response:

1. Ensuring effective and timely communication;
2. Supporting community populations and caregivers;
3. Supporting residential care facilities; and
4. Facilitating appropriate care transitions.

The four areas are outlined in this report and provide the lens for the recommendations.

While COVID-19 has illuminated challenges in our health care system, the findings from this report point to areas of opportunity to strengthen programs serving dually eligible individuals both in times of emergency and beyond the current pandemic. There are over 10 million full benefit dually eligible individuals served by a patchwork of Medicare and Medicaid providers. As highlighted in the discussions with health plans and states, the current fractured system design has only been exacerbated during COVID-19. The challenges with the pandemic have only reinforced the need for a more aligned and coordinated structure for this complex population. Key findings from interviews with states and health plans[2] indicate that programs serving dually eligible individuals are faced with a multitude of new and exacerbated issues as a result of COVID-19 and that plans and states can respond with a range of innovations.

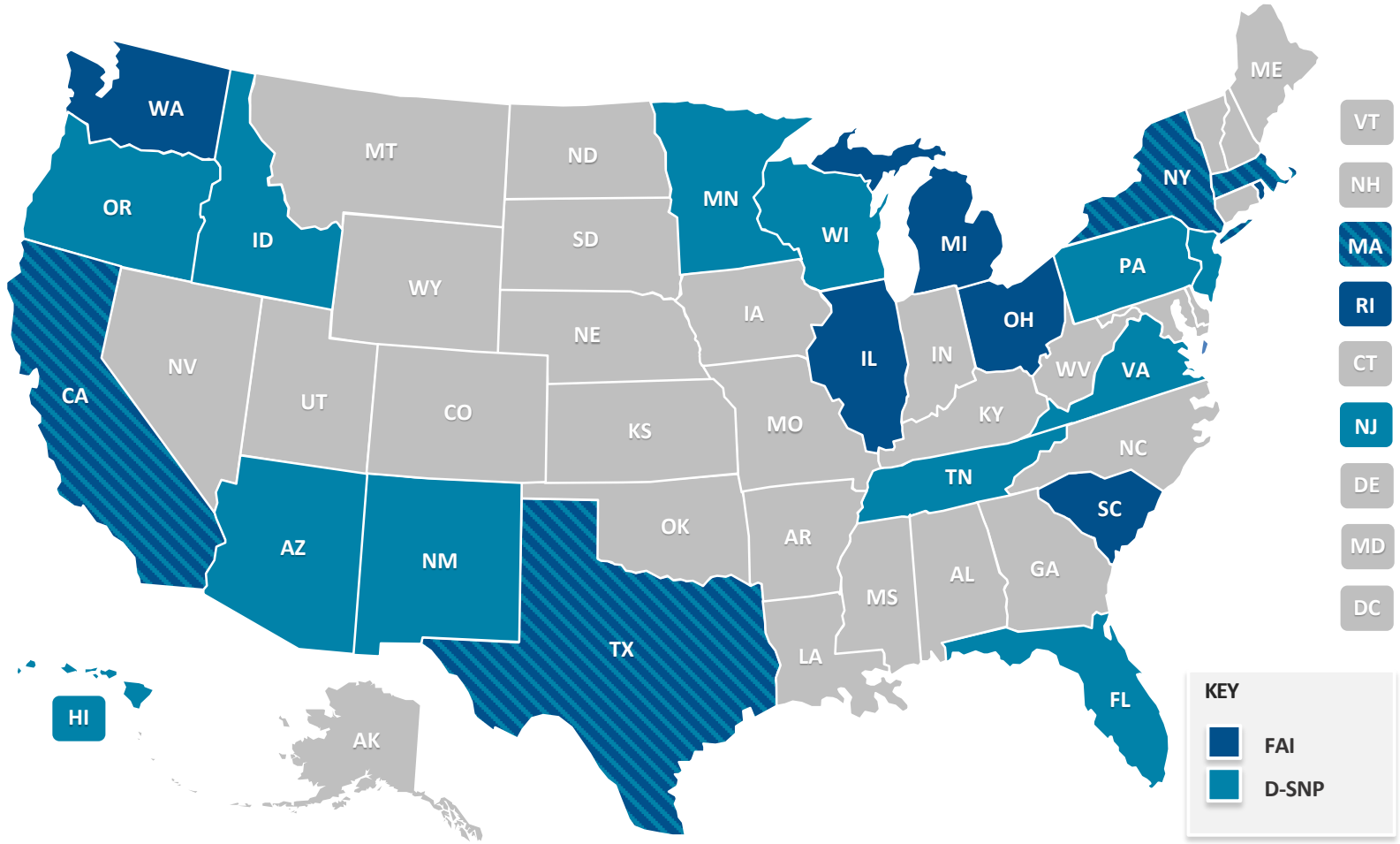
Introduction

COVID-19 has put an incredible strain on the health care system. States and health plans that manage services for this population are continually adjusting policies and programs to respond to this crisis. And, as recent Medicare data demonstrates, dually eligible individuals are among the highest-risk for serious illness and hospitalizations from COVID-19.[3]

Dually eligible individuals are normally at greater risk than the general population to have significant medical and social support needs, and with COVID-19 there is a heightened risk for social isolation, food insecurity, and behavioral health challenges. COVID-19 is also increasing the complexity of transitions of care for those living in institutional settings, as well as those in the community. While states and health plans vary in their approaches to integrating Medicare and Medicaid services, the COVID-19 pandemic has been a tragic opportunity to see how integration may address the needs of dually eligible individuals and help policymakers in their ongoing response to this crisis. Sharing this information can also help to make the case for expanding the limited enrollment in integrated care options nationally to better serve this population. See Exhibit 1 (next page) for a map of the status of integrated care for dually eligible individuals nationally.

This report, developed by Speire Healthcare Strategies and CHCS with support from Arnold Ventures, outlines key response efforts undertaken by state Medicaid agencies and health plans serving dually eligible individuals. To gain insights and form recommendations, the team reviewed recent articles, data, and reports from the Centers for Medicare & Medicaid Services (CMS), and conducted interviews with industry leaders.[4] Based on the information collected, the authors developed a series of policy and programmatic recommendations. The recommendations are intended to provide state and health plan leaders with tangible solutions that can be quickly implemented to help them respond and meet member needs throughout the pandemic. As the pandemic remains a significant threat to this vulnerable population, it is critical that leaders leverage effective policy and program strategies.

Exhibit 1. Integrated Care Models in the United States (as of October 2020)



Background on COVID-19 and Dually Eligible Individuals

Dually eligible individuals have experienced COVID-19-related hospitalization rates more than 4.5 times higher than individuals covered by Medicare only (719 versus 153 per 100,000).[5] This group includes heterogeneous sub-populations of individuals with varying needs — including elderly individuals over age 65, people with intellectual and developmental disabilities, and individuals under age 65 with certain physical disabilities and/or serious mental illnesses.

Given the complexity of the population, the need for coordination across physical and behavioral health care, long-term services and supports (LTSS), and other social support programs is critical for dually eligible individuals. However, most dually eligible individuals are enrolled in fragmented Medicare and Medicaid systems without supports to navigate across the two programs. In 2019, just over one million of the more than 10 million full benefit dually eligible individuals were in integrated care models.[6] States have developed various integrated care models for dually eligible individuals, including aligned D-SNP programs and FIDE-SNPs that are closely coordinated or integrated with Medicaid managed long-term services and supports (MLTSS) programs, and MMPs that operate under the federal FAI.[7] Within the regulatory parameters of the various programs, health plans have flexibility to innovate in order to provide coordinated care most effectively across both sets of services for this vulnerable population. Despite variation in the level of integration and coordination in these programs across state and health plan levels, having aligned membership with strong benefits and data sharing can best support COVID-19 response efforts.

The high prevalence of COVID-19 among LTSS users underscores the importance of integrated medical care and LTSS delivery. Nursing and assisted living facility residents experience significantly higher COVID-19-related mortality than the general population, especially at the outset of the pandemic before appropriate safety protocols and personal protective equipment (PPE) could be secured. With approximately 25 percent of dually eligible individuals residing in a nursing facility,[8] it is critically important for integrated programs to support residential facilities. Dually eligible individuals residing and receiving supports in the community experience their own set of risk factors and issues exacerbated by the pandemic, including new and worsening behavioral health issues.

Interviewees identified several key policy and programmatic areas of concern for state Medicaid agencies and health plans that support dually eligible members both in facilities and in the community. States and plans have experienced certain issues directly related to serving dually eligible individuals during the COVID-19 pandemic, such as the need for PPE, and COVID-19 testing for individuals, families, caregivers, and providers. There are also several key issues that systems serving dually eligible individuals experience on an ongoing basis which have been exacerbated by the COVID-19 pandemic. These issues include:

- Securing adequate caregiver resources and providing them with necessary supports;
- Ensuring members continue to have access to needed medications, preventive screenings, and maintenance care for chronic conditions through in-person and expanded telehealth capacities;
- Recognizing changing utilization patterns and developing responses by states and health plans to ensure appropriate allocation of funds to support new services now utilized;
- Facilitating transitions of care from place of residence to setting of care and discharge back to a residence and monitoring care transitions amid the pandemic; and
- Delivering timely and accurate information to members and their families related to COVID-19 facts, safety measures, testing updates, and service and supports updates.

These issues are a common theme woven throughout the key response efforts and policy recommendations described in this report.

Key Response Efforts

State Medicaid agencies and health plans serving dually eligible individuals were faced with immediate challenges at the outset of the COVID-19 pandemic, which required quick action to keep members safe. As the pandemic continues, both states and health plans have shifted their focus to determining which measures should be implemented in the short- and long-term.

1. Ensuring Effective and Timely Communication

All interviewees noted the need to ensure that members, providers, and health plan staff were informed on the latest, most reliable information about COVID-19, and available resources. Lack of information at the outset of the pandemic regarding how COVID-19 spread, who was most susceptible, and proper safety protocols presented immediate challenges for health plans and states. Communicating facts, allaying fears, and helping members understand that the pandemic will likely be around longer than originally expected is an ongoing focus for states and plans.

States and plans deployed a range of strategies as each tried to provide timely information to key partners and the community. For example, Virginia held daily meetings with health plans at the outset of the pandemic. Although they are less frequent, the state still provides regular information sharing and communication about ongoing regulatory flexibilities to support bidirectional dialogue between the state and contracted health plans on emerging concerns and available resources.

Many plans, including Molina and Mercy Care, implemented forms of daily "command centers" staffed by key leadership and clinical staff to identify needs, challenges, and issues as they arose to enable quick, coordinated resolutions. Mercy Care leveraged these data points to develop strategic response tactics including using social media, sharing frequently asked questions, updating their website, providing webinars, and sending provider notices to disseminate critical and timely information. While the degree of information shared by interviewees varied, some regularly shared data with each other on member positivity rates, transitions of care across institutional and home settings, provider inquiries, and other critical data points to enable rapid implementation of effective response efforts.

2. Supporting Community Populations and Caregivers

Assessing Member Needs

At the outset of the pandemic, there were many uncertainties that required reassessment of both provider and member needs. States and plans had to quickly re-evaluate how to ensure members were safe and secure, with all their social needs being met in the face of stay-at-home orders and

uncertainties around transmission. Many plans reported making outreach calls to high-risk, or in some cases, all members to establish an understanding of immediate needs and what new supports and services might be necessary to ensure the member remained safe in their home.

*i*Care reported making initial phone calls to every Family Care Partnership[9] member within 10 days of face-to-face visits being suspended, telephonically assessing health and safety to make sure critical LTSS were in place and conducting initial COVID-19 screenings and education. Based on these calls, *i*Care set up ongoing calls with most members at weekly or bi-weekly intervals depending on risk levels, to maintain stability. Certain members, mainly those in skilled nursing facilities (SNF), are called monthly to reduce burden on SNF employees during the pandemic.

VNSNY CHOICE created a dashboard to track selected metrics daily to inform care management interventions for its dually eligible members. The dashboard supports efforts across home- and community-based (HCBS) and institutional settings and includes information such as whether a member tested positive for COVID-19, based on a lab or physician test or from a symptoms-only diagnosis. VNSNY CHOICE uses claims data, as well as information from aides and other service providers, to create the dashboard. VNSNY CHOICE care managers use the status on the dashboard — positive, positive-suspected, negative — to appropriately follow-up with the member. This information was particularly helpful as New York was one of the first COVID-19 hotspots before testing became more readily available. VNSNY CHOICE shared as much information as possible with its provider partners to inform care management and delivery efforts. The dashboard also supports risk stratification efforts and provides a vulnerability index that is shared with home care provider partners. The information sharing helped to ensure that providers and the plan were in alignment on which members they considered high-risk.

Workforce Challenges and Supporting Caregivers

Supporting the LTSS workforce, including adult day centers, personal care attendants, and formal and informal family caregivers is a critical element in the COVID-19 response efforts of states and health plans serving dually eligible individuals. According to a survey by the National Association of Home Care and Hospice, approximately 64 percent of home health and home care providers were serving COVID-19 patients as of May 2020.[10]

States and plans have taken a number of approaches to bolster the caregiver workforce. For example, in April 2020, the state of Arizona approved temporary payment for family members to serve as direct care workers for children with developmental disabilities and temporarily increased respite hours. Later that month, it announced temporary incentive rate adjustments to specific services to retain and recruit direct care workers.[11] Similarly, Virginia made changes to allow parents of minors or spouses to serve as paid caregivers to alleviate gaps in care experienced because attendants were fearful of contracting COVID-19 when providing in-home care.

Molina had previously implemented the American Medical Association's caregiver stress screening tool and uses this to monitor for increased stress levels to identify caregivers who need additional community-based resources. It offers a caregiver support program to address identified needs and help prevent barriers to services based on the inputs from the tool. Centene is also leveraging its Caregiving Collaborations program, which includes a caregiver questionnaire developed in partnership with the National Alliance on Caregiving, to identify and better support the needs of caregivers during COVID-19.[12] Centene has also partnered with ADvancing States to build a website that will help match direct care workers and other health services personnel with open positions in home care, residential care settings, and hospitals to bolster the workforce during the immediate needs of the pandemic and into the future.

Centene Emergency Worker Pilot Program

The COVID-19 pandemic has led to disruptions for people who self-direct their home care resulting from direct care workers being subject to stay-at-home orders or isolation, having difficulty accessing PPE and child care, or refusing to care for individuals who become sick or are exposed. When family members — who are often these individuals' emergency backup attendants — also get sick or exposed, the individual requiring care may be at risk of institutionalization. To address this, in less than three months, Centene and its affiliates in Kansas and Pennsylvania (Sunflower Health Plan and Pennsylvania Health & Wellness) collaborated with the National Council on Independent Living, Association of Programs for Rural Independent Living, Liberty Resources, Southeast Kansas Independent Living Resource Center, and Topeka Independent Living Resource Center to launch an emergency direct care worker registry and backup pilot for consumers who self-direct. Consumers can call a 1-800 number and an emergency direct care worker is dispatched to their home in 60-90 minutes. To get creative in finding workers for the pilot, Centene is partnering with the Therapist Action Plan project, which supports occupational therapy students experiencing difficulties finding field work placements during the pandemic. Pennsylvania Health & Wellness partnered with Philadelphia Works, the local workforce investment board, to recruit direct care workers.

Meeting Social Needs

Addressing their social needs is critical to helping dually eligible individuals remain safe and healthy in the community. Healthy meals, access to safe and reliable transportation, secure housing, and supplemental supplies, such as masks and hand sanitizer, are vital resources that states and health plans can help connect individuals with in their communities. States and health plans quickly identified both existing benefits to build on and new opportunities to address social needs in response to the pandemic.

Ensuring individuals had appropriate meals was a common concern for states and plans. Minnesota reported access to meals being one of the most immediate issues that had to be addressed for their dually eligible population, since individuals and the family members that support them were under stay-at-home orders. It leveraged Older Americans Act funding to provide additional meals that were coordinated by health plans and the counties. Minnesota also implemented an alternative day benefit to help combat issues with social isolation for the population that was receiving adult day benefits that were paused at the outset of the pandemic.[13]

This alternative day benefit allows providers to deliver services remotely, either one-to-one or in small groups. These services are supplemented with in-person services, such as delivery of meals by adult day providers. As Minnesota began to partly reopen traditional group adult day services in July, it has kept the alternative day service as an option for providers and members.

In states that allow in lieu of services or other latitude through waiver flexibility for value-added benefits, Molina launched an emergency meals program that provides up to two weeks of home-delivered meals, including a shelf stable option to complement their existing transitional meal program in their D-SNPs, FIDE-SNP, and MMPs. This was offered to all eligible members who might need the nutritional support during the pandemic, not only individuals with positive COVID-19 diagnoses. Molina also provided monetary and in-kind donations to several community-based organizations that offer important social supports. For example, through Molina's relationship with Prospera Housing Community Services in Texas, Prospera provided rent assistance, wellbeing outreach, and more than 12,000 meals to Molina members.

UPMC deployed rapid response teams to supply immediate access to critical resources its community-based members needed, such as groceries, medications, and PPE. UPMC also experienced an uptick in utilization of its over-the-counter D-SNP benefits, particularly the mail order service that offers members access to items such as hand sanitizer and gloves delivered to their homes.

Providing transportation for individuals who were COVID-19 positive, or potentially positive, was a challenge across states and plans. Multiple plans in Minnesota reported having to renegotiate transportation contracts in response to vendors' concerns about risks associated with transporting positive or potentially positive members.

Supporting members receiving ongoing preventive care is another critical issue facing states and plans as the pandemic persists, along with the fear associated with risking infection by visiting providers' offices. Many plans in Minnesota's Senior Health Options (MSHO) program[14] took advantage of additional flexibilities to provide supplemental services. In response to COVID-19, one MSHO plan began actively promoting the use of in-home test kits for A1c levels and colorectal cancer screenings to encourage members to continue to monitor their health at home.

Meeting Behavioral Health Needs

Approximately 49 percent of dually eligible individuals under the age of 65 have behavioral health diagnoses.[15] Anxiety, depression, and substance use disorders, for example, not only significantly impact individuals' mental health, but also create higher risks of comorbid conditions or exacerbation of chronic diseases if not appropriately managed. Delivering care to dually eligible individuals with behavioral health needs is an ongoing priority for states and health plans as new conditions arise and existing conditions are exacerbated due to concerns around the pandemic. Health plans identified a number of approaches to evaluate and respond to existing and increased behavioral health needs resulting from the pandemic.

At the outset of the pandemic, Molina conducted outreach calls to all members, prioritizing those most at risk for institutionalization and readmission. This proactive approach enabled Molina to identify and address an uptick in members experiencing behavioral health issues such as anxiety, hoarding, stock piling, and self-isolation as they adjusted to the "new normal."

iCare, along with other Family Care Partnership[16] plans, set up a series of calls with a subset of providers who serve members with complex behavioral health needs. The health plans and providers discussed emerging provider needs to continue to effectively serve members in the current environment. The group brought recommendations back to the Wisconsin Department of Health Services, including a plan for system collaboration to serve members who were seeing providers facing staffing limitations. These recommendations are now being brought by the state back to a larger emergency systems team.

Continuing to engage members in ongoing outpatient services is especially important during this time to limit exacerbation of behavioral health conditions. Mercy Care and their providers have used telehealth to address many behavioral health issues experienced by its members. However, some services for members with serious mental illness cannot be delivered remotely, such as the provision of certain medications and injections. To better address these challenges, Mercy Care collaborated with a range of providers, including behavioral health providers, to adopt additional infection control measures and implement new procedures to ensure members' mental health needs could still be met as the pandemic evolves. Mercy Care is working with providers to develop a hybrid model and parse out what can be delivered to this population through telemedicine and what needs to be delivered in-person, and how to do so safely.

Partnering to Meet the Needs of Homeless Individuals in Phoenix, Arizona

In 2020, Arizona's Maricopa County, which includes Phoenix, counted nearly 7,500 homeless individuals.[17] At the outset of the pandemic, the community partnered to coordinate a response effort to COVID-19 for this critically vulnerable population. Mercy Care and other integrated health plans serving this region partnered with the state's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), the Homeless Continuum of Care Homeless Management Information System (HMIS), city and county agencies, Central Arizona Shelter Services, Circle the City, and Resilient Health to coordinate care and find housing options for members experiencing homelessness amid the pandemic, as well as promote early implementation of effective social distancing, sanitation, and face-covering practices. The city and county deploy navigators to engage the homeless population and provide needed transportation and other services. HMIS and AHCCCS regularly identify persons experiencing homelessness who are COVID-19 positive. Each week, health plans receive a list of their members to support targeted outreach. As of late August 2020, the list included over 500 identified members. To support members residing in subsidized housing, Regional Behavioral Health Authorities in Arizona have conducted wellness checks on AHCCCS members to evaluate social and financial COVID-19-related concerns and address issues before crises occur.

3. Supporting Residential Care Facilities

Financial and Other Resource Supports

Nursing and other residential care facilities such as group homes and assisted living, have experienced significantly increased financial burdens related to COVID-19, such as requiring additional staff overtime, increasing sanitation protocols, and purchasing PPE supplies. States and health plans have devoted substantial attention and resources to meeting the needs of their nursing facility partners. States have enhanced payments and reduced administrative burdens, while health plans have donated employee volunteer time-off hours, PPE, and cleaning supplies to facilities in critical need.

The state of Minnesota implemented an Appendix K waiver amendment to provide a temporary 50 percent rate increase to 45 days for customized living services (assisted living) providers that have had at least one confirmed case of COVID-19 among residents or staff, as determined by the Minnesota Department of Health. The rate increase helps providers handle COVID-19-related costs including staffing, purchasing PPE, and implementing additional infection control measures.[18]

The state of Virginia provided nursing facilities with a $20 per day supplemental payment for every covered member in May 2020 with retroactivity to March to support facilities' significant needs in accessing PPE and additional staffing. Health plans collaborated with Virginia in the initial planning and delivery of payments as the state built a claims process for the additional payments.

Increasing Access to Technology to Reduce Social Isolation and Improve Access to Virtual Care

As residential care facilities began prohibiting or more recently, limiting outside visitors, social isolation became an immediate concern for the already vulnerable populations residing in these facilities. While dually eligible individuals' eagerness and ability to engage with technology varies, supplementing services and supports with technology in residential settings is a common strategy used by health plans to reduce social isolation and improve access to virtual health care.

For instance, one MSHO plan in Minnesota is providing animatronic cats to individuals with dementia to help with anxiety. The plan also has leveraged the iPads it already provides to many members to share additional COVID-19 education and testing resources and information on additional supports. Centene, as part of its Social Threads program, is distributing hundreds of tablets to residential facilities in eight states to help residents reconnect with family, care coordinators, and providers outside of the facility.

Reducing Administrative Burden and Improved Data Sharing

COVID-19 has placed extreme strain on nursing and other residential care facility staff to not only provide critical medical care while managing heightened infection control measures, but in many cases, to serve as the sole social support for residents during a stressful time.

To alleviate administrative burden, both Molina and Centene implemented new or expanded partnerships with nursing facilities to gain remote access to the facilities' electronic medical records (EMR). This access allows health plan care coordinators to review member charts in the facilities without relying on the limited nursing facility staff to report to plans on changing member needs. Centene's Pennsylvania plan now has access to EMRs in about 80 percent of its nursing facilities statewide, except for the particularly rural southeastern part of the state. In this area, the plan is distributing tablets to facilities to enhance coordination and communication as part of the Social Threads initiative. In addition, Molina has donated laptops and tablets to facilities with technological barriers to accessing critical information and virtual services and connecting with social supports.

States have implemented new mechanisms and leveraged existing resources to communicate data to plans on member positivity and outbreaks across facilities to ensure critical information sharing. Recognizing the need for improved data sharing between skilled nursing facilities and health plans, and the critical nature of coordinating care for residents in facilities with COVID-19 positive cases, Wisconsin Department of Health Services began sending out daily feeds to health plans of SNFs and residential facilities that have COVID-19

positive cases. iCare uses this information to support its outreach and care management efforts to identify members who may be at particular risk if housed in a facility with a positive case.

Similarly, AHCCCS has leveraged the statewide health information exchange (HIE) to provide COVID-19 test results within 24 hours of receiving results to its health plans to support care coordination and delivery of additional supports as needed.[19] Mercy Care, which operates in Arizona, identified the capacity to receive real-time laboratory alerts as an important part of their ability to identify members and target locations most affected by the pandemic.

4. Facilitating Appropriate Care Transitions

States and health plans have varying levels of readily accessible information on inpatient admissions and emergency department (ED) visits for dually eligible individuals. The Bipartisan Budget Act (BBA) of 2018 outlined requirements for D-SNPs to increase coordination that were later promulgated in 2019 CMS guidance to promote care coordination across D-SNPs and Medicaid by 2021.[20] While these requirements should increase the number of states and plans with improved data-sharing capabilities, current information-sharing platforms are sparse and inconsistent. Further, data on discharges is not currently widespread nor is it included in the new requirements, but it holds great value for health plans supporting members throughout their care transitions.

Particularly in hotspots heavily affected by COVID-19, nursing facilities experienced large volumes of individuals being discharged from hospitals to nursing facilities, when the transition could have been to the community with appropriate measures. This trend continues as spikes in cases emerge. For individuals who receive daily LTSS in an aligned Medicare-Medicaid plan, health plans can identify inpatient admissions and intervene to support improved transitions. Molina has conducted outreach calls to all its members being transitioned to ensure they land in safe and supportive environments. In addition, in Florida, where the Medicaid agency sends health plans same-day electronic notification of ED use and admissions to health plans (including Medicaid plans for unaligned dually eligible members), Molina takes immediate action to ensure the member is safely discharged to the least restrictive setting with needed social supports and services to prevent avoidable institutionalization and readmission.

Mercy Care credits its strong, long-term relationships with its provider network, and its partnership with the state HIE, as being critical to ensuring it is notified by EDs and hospitals when their members are admitted, as well as for identifying members with new infections at any location in the State. Approximately 95 percent of Arizona's acute care hospitals participate in the HIE, providing admission and discharge notifications to the HIE. All AHCCCS health plans are participants in the HIE and receive these notifications.

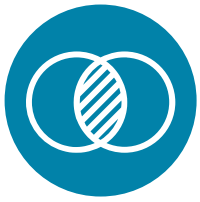
Arizona's Case Staffing for COVID-19 Positive Individuals with Developmental Disabilities

The Arizona Department of Economic Security's Division of Developmental Disabilities (DDD) manages the state's program for individuals with developmental disabilities. At the outset of the pandemic, the DDD facilitated a daily case staff meeting each morning to ensure all COVID-19 positive individuals and their families in the program were receiving the necessary supports. This hands-on approach enabled the DDD to monitor appropriate service delivery and availability to ensure continuity of care. Staff from Mercy Care's care and utilization management teams participated in these meetings weekly to help coordinate care across the continuum in conjunction with all key stakeholders.

Policy Recommendations

State Medicaid agencies can strengthen their programs in a number of ways to better respond to the needs of their dually eligible individuals as the COVID-19 pandemic persists and prepare for potential future disease outbreaks moving forward. Specific recommendations for state Medicaid agencies and health plans are below.

1. Increase Alignment Between Medicare and Medicaid



State and health plan interviewees consistently reinforced that health plans that cover a member's Medicare and Medicaid benefits can more quickly support them in times of crisis such as during COVID-19. With only 10 percent of dually eligible individuals receiving care through an aligned platform, states have significant opportunity to expand their programs to integrate enrollment, services, and financing.[21] Aligned or integrated plans have access to the individuals' complete health care data and can more nimbly respond to deliver appropriate services. States can create policies that advance aligned enrollment into integrated plans, while health plans have additional levers to promote activities that encourage enrollment into these programs.

- **State Medicaid Agencies** can pursue a number of paths to advance aligned care for dually eligible individuals. Key options for states to expand and refine aligned care include:
  - **D-SNP SMAC Provisions:** D-SNPs must sign SMACs with each state agency to operate in a state. States can choose which, if any, D-SNP SMACs to sign. SMACs provide states with a tool to incrementally advance aligned, integrated, and coordinated care. States should establish a clear strategy on how to best pursue alignment in their state with input from all key stakeholders. Informed by this direction, states can choose from a range of SMAC provisions to include in their contracts to advance their goals. For example, requiring D-SNPs, or their parent companies, to operate MLTSS plans; requiring information sharing between D-SNPs, Medicaid health plans, and other key partners and payers; implementing and expanding default enrollment; limiting D-SNPs to those operating MLTSS plans; and reporting on metrics of importance for program planning.
  - **D-SNP and MLTSS/Behavioral Health Services Integration:** Depending on how existing programs are designed, states can consider carving in LTSS and/or behavioral health services into Medicaid managed care contracts and aligning those contracts with companies operating D-SNPs. States can require the same health plan operating a D-SNP to provide MLTSS and Medicaid managed behavioral health programs or require comprehensive coordination between programs. This sets the foundation for delivery of integrated and coordinated care by ensuring that dually eligible individuals are enrolled in a single organization.

  - » **FAI Open Opportunity:** In April 2019, CMS reintroduced the FAI for states to expand existing demonstrations or test new demonstrations including capitated models which leverage MMPs and Managed fee-for-service models (e.g., Washington State); or state specific models such as Minnesota's Administrative Alignment demonstration.[22] Independent evaluations by RTI International[23] show that MMPs have achieved statistically significant cost savings, better performance than benchmarks on quality measures, fewer SNF and hospital admissions, and the highest levels of beneficiary satisfaction. States interested in pursuing this option should contact the Medicare-Medicaid Coordination Office at CMS to understand integration options.

- **Health Plans** can send letters to their Medicaid health plan members[24] that are not currently in an aligned Medicare product to educate members on the benefits of being with the same organization for the delivery of both Medicare and Medicaid services. Plans can also provide resources to state Medicaid agency partners to implement policies and program changes that require some resource investment on behalf of the state, such as default enrollment.

2. Increase Plans' Flexibilities to Address Member Needs

CMS has provided several opportunities for states and Medicare entities to enact program flexibilities to better respond to COVID-19. Although each state has a unique Medicaid program designed to best serve its population, some protocols can be restrictive and delay vital care and services in times of emergency, such as during COVID-19. To enable state programs and their health plan partners to respond nimbly and appropriately to the unique and evolving needs of dually eligible individuals, states are and will continue to evaluate existing regulatory constraints on plans. For example, HCBS 1915(c) Appendix K waivers provide a standalone option that states may use during emergency situations to request amendments to existing programs to support emergency response actions for the HCBS population. Certain other activities may require the use of different authorities such as the Section 1115 or Section 1135 demonstration authorities.[25] Almost all states have submitted and received approval for Appendix K waiver authority since the beginning of the pandemic. While states request these flexibilities to support all Medicaid HCBS users, dually eligible individuals represent a high percentage of the population that benefit considerably from the changes. Key focus areas of the waivers include:

- Expanding settings where services may be provided. This includes the use of telehealth for case management and personal care service delivery that require only verbal cues;
- Increasing Medicaid payments to HCBS providers to support costs of PPE, staff, and additional sanitation;
- Expanding provider qualifications and allowing previously unpaid family caregivers to receive payment; and
- Modifying level of care evaluation processes.[26]

While many states requested the same or similar changes, there are implementation nuances across states that can be helpful to inform additional changes. As the pandemic persists, states are reevaluating which flexibilities they hope to extend.

Support Utilization and Expansion of Telemedicine and Telehealth

- **State Medicaid Agencies** can allow plans to conduct official assessments via video conference when an in-person visit is unsafe or preferred by the member. States can also support wider adoption of telemedicine through expanding reimbursements for telephonic visits and telehealth services that are more limited across states. Telehealth solutions to supplement socialization provided by adult day centers may not be ideal as a total replacement to in-person services; however, there is great value in offering additional options for certain members to ensure some contact during times when full socialization is riskier.
- **Health Plans** can support continued use and expansion of telemedicine and telehealth services through expanded offerings and partnerships with hospitals and network providers. Also critically important is for plans to ensure the prioritization of assessing and addressing members' access to technology and internet, and providing training as needed, to enable utilization of telemedicine and telehealth services. Plans can connect members with additional supports through direct or indirect gifting. Plans can also prioritize referrals of members to low-income internet providers or otherwise assist members in achieving access. Throughout these efforts, plans should support states' telemedicine and telehealth strategies by sharing metrics on successes and concerns with current strategies.

Relax Regulations to Enable Greater Flexibility to Meet Members' Needs

- **State Medicaid Agencies** can extend or establish new relaxed expectations around face-to-face care coordination and care management that take into account the benefits and opportunities of improved technological advancements, but also ensure the needs of individuals are being met and maintained. States can also evaluate permanently relaxing regulations that have financial thresholds for gifts to members to allow plans to buy additional supports specific to member needs. Having the policy in place to allow plans to provide additional supports, such as gifting iPads directly to members, in times of future potential crises can expedite these processes and allow for the faster resolution to a variety of issues member's face.
- **Health Plans** can support their state partners by identifying and providing recommendations on how to address regulatory hurdles to enable them to better meet member needs. Plans can gather and share data with state partners to demonstrate clinical or financial improvements related to certain benefit flexibilities to advance positive policy changes, both in the immediate term to address pressing concerns and in the long term to improve response efforts. Plans can also think creatively and partner with community-based organizations to facilitate the distribution of additional benefits to support members.

3. Pay Family Caregivers and Support Other Efforts to Expand the Workforce

Family caregivers are the largest health care workforce today with nearly 40 million adults currently caring for a family member or friend age 50 or older across the US.[27] Given the large number of dually eligible individuals who use LTSS or who have functional impairments, health plans and state programs for dually eligible individuals have a particular interest in supporting family caregivers and other direct care workers to enable their members to stay in the community and avoid unnecessary facility placements. The COVID-19 pandemic has put a spotlight on the critical role family caregivers play in delivering care to vulnerable individuals, as well as the challenges with the supply of direct care workers to meet the growing demand. Social isolation, caregiver burnout, lack of access to and/or comfort with technology, limited health navigation skills and interactions with health care facilities, and financial hardship of family caregivers are all issues exacerbated by COVID-19.[28]

- **State Medicaid Agencies** can pursue Medicaid flexibilities that support family caregivers, including pursuing HCBS 1915(c) Appendix K waivers or Section 1115 demonstrations to allow for payments to family caregivers; partnering with system stakeholders to identify families with the most critical needs; and promoting interagency and other stakeholder collaborations.[29] State agencies can also require health plans to: report to the state how the plans are meeting the workforce needs; participate or convene collaborations with stakeholders to identify opportunities to grow the workforce; and work with vocational rehabilitation or other public programs to connect to potential workers.
- **Health Plans** can collaborate with caregiver associations and other plans to provide feedback to states regarding what flexibilities or additional supports can assist the caregiver workforce. Plans can identify partnerships with non-traditional organizations to bolster workforce supply and better support families at home, such as the Emergency Direct Care Worker program that Centene developed in Pennsylvania- and Kansas-based Centers for Independent Living and its partnership with occupational therapy students to fill gaps in the workforce while giving students critically needed fieldwork.

4. Expand Supplemental Benefit Offerings

Medicare Advantage plans serving chronically ill individuals were given new flexibility through the BBA to implement Special Supplemental Benefits for the Chronically Ill (SSBCI) to address individuals' social needs. Unlike most Medicare Advantage benefits, these supplemental offerings can target a subset of enrollees with specific chronic conditions and seek to improve health through non-medical means. In 2020, only 10.2 percent of SNPs[30] offered SSBCI, the most common benefit being pest control, food, and transportation for non-medical needs.[31] The COVID-19 pandemic has illuminated the critical role social determinants of health play in the

life of dually eligible individuals. It has become clear that the systems in place to provide necessary daily supports are fragile and need to be reinforced for both short- and long-term success. Throughout health plan and state interviews, the most common need identified among dually eligible individuals was home-delivered meals. Many plans mentioned that their current robust D-SNP and MMP benefit packages offered sufficient meals.

- **State Medicaid Agencies** can add contract requirements in their D-SNP SMACs that require D-SNPs to collaborate with the state on supplemental benefit offerings. This can allow the state to assess its ability to require D-SNPs to offer supplemental benefits, including SSBCI. Sample language from Arizona's D-SNP SMAC can be found in Exhibit 2.
- **Health Plans** with sufficient financial resources can prioritize adding supplemental benefits to their D-SNP benefit packages that directly address some of the most pressing needs resulting from public health emergencies such as COVID-19, including additional meals that are not tied to an inpatient stay and expansion of telehealth opportunities across physical and behavioral health. Additional over-the-counter benefit offerings that include mail delivery can also be particularly important for dually eligible individuals during times of economic stress and social distancing. Integrated plans are also in a good position to evaluate how they can use Medicare supplemental benefits to wrap around Medicaid services available to their members.

Exhibit 2. Sample Supplemental Benefits Contract Language

Arizona's 2020 D-SNP SMAC includes the following language that could be useful for other states:

> The [Medicare Advantage Organization] MAO shall collaborate with AHCCCS regarding discretionary health-related supplemental benefits to be offered under the [BBA] and [SSCBI] to be offered beginning CY2020 under authority provided by CMS in the Medicare Advantage CY2020 Final Call Letter issued April 1, 2019. Such coordination shall include proposed prospective SSCBIs that have a reasonable expectation of improving or maintaining the health or overall function of such an AHCCCS Dual Eligible Member as tailored to the individual's needs, for those such who are enrolled with the MAO. AHCCCS seeks to improve Medicare-Medicaid program coordination of such SSCBIs to reduce service delivery fragmentation and promote improved health outcomes. Examples of such coordinated SSCBIs include, but are not limited to home delivered foods/meals, home environmental modifications, transportation for non-medical needs, and other identified social determinant of health needs on a per identified and defined chronically ill Dual Eligible Member basis as documented in their care management/care treatment plan.

5. Improve Communication and Data Sharing

Develop Robust Communications Strategies

Ensuring that timely and appropriate messages reach dually eligible individuals, their families, and providers has been a critically important part of response strategies since the onset of the pandemic. With no clear end in sight, it is vital that states and plans continue to communicate and reach members through innovative strategies. As treatments are developed and a potential vaccine is approved for use in the United States, clear, direct messaging needs to be prioritized to ensure that all stakeholders, members, and their families are informed and understand how to access critical services. Building trusting relationships with individuals and their families is critical to supporting effective communication and outreach.

- **State Medicaid Agencies** can require health plans to implement a state-approved communication plan for members, families, and providers that allows for ongoing input from the state to determine core components of critical messages. States should also consider establishing ongoing platforms for key stakeholders to receive the latest messaging from the state through different modalities such as regular conference calls, website updates, and social media updates.
- **Health Plans** can continually monitor and evaluate their messaging strategies, seeking regular input on messages from members, families, and providers to ensure communications and the modes of delivery are clear and sufficient. A diverse set of modalities to share communications is critical to reach all members, including using member engagement staff, provider and community-based organization partners, traditional mail, website updates, and social media. Communication plans should be fluid and continually updated to reflect the most current evidence as new treatments, testing, and vaccines are identified and approved.

Enhance Data-Sharing Platforms

While the best option for dually eligible individuals is to receive their care through a single source, electronic data exchange and enhanced interoperability between payers, hospitals, and skilled nursing facilities can significantly improve how health plans can support their members. States with robust HIE programs are at an advantage for sharing real-time data to support care management for dually eligible individuals. States and health plans, however, can enhance data-sharing efforts without such infrastructure in place.

- **State Medicaid Agencies** can require health plans to develop data-sharing platforms with hospitals to ensure plans receive timely data on member hospital admissions, ED visits, and discharges. Some states are requiring D-SNPs to share hospital admission and ED visit information that they are privy to, but are not mandating electronic exchange with hospitals. Under BBA D-SNP requirements[32], going into effect January 1, 2021, states will establish requirements for certain non-integrated D-SNPs to share inpatient

admission and ED visit information with the state or its designee. However, not all states and plans will be pursuing these connections and many states will not be requiring inclusion of all D-SNP populations. Timely discharge data is not a component of BBA requirements, but such data could be a useful addition to share both during public health emergencies and under normal circumstances. States can also go beyond BBA requirements and mandate that D-SNPs share data with unaligned payers for their D-SNP members who receive Medicaid coverage through a different organization. This requirement will further strengthen plan data-sharing platforms to support care coordination.

- **Health Plans** can develop strong relationships with hospital providers to encourage information sharing. Health plans can designate care managers to staff key hospital settings or SNFs with high volumes of membership to work with discharge planners to facilitate more immediate care coordination. Health plan staff including care managers, coordinators, or community health workers can also work closely with family caregivers to provide support to ensure they fully understand discharge instructions. Working with SNFs, plans can develop systems to access facility EMR systems to remotely manage member care, which is especially important in times when SNF staff are under significant strain.

Regular Reporting on Utilization and Trends

State Medicaid agencies serving dually eligible individuals through managed care programs monitor regular business practices and outcomes in varying capacities. Emergency response efforts to address the needs of dually eligible individuals should collaboratively engage all stakeholders and employ tools to monitor and ensure response strategies are effective and considerate of community needs.

- **State Medicaid Agencies** can add requirements to MLTSS health plan contracts and/or D-SNP SMACs depending on state programs that require plans to submit pertinent data on the impact of COVID-19 or other public health emergencies, as well as the plans' response efforts to ensure appropriate services are being delivered and identify opportunities for improvement.
- **Health Plans** can share data with states on utilization patterns and changes that have resulted from COVID-19. Such data can be used to identify systemic gaps in state-wide resources such as pediatric ventilators and oxygen machines.

6. Ensure Fiduciary Oversight

COVID-19 has changed how individuals use health care services. States have reported significant declines for some health care services, including outpatient and specialty care. At the same time, other providers have seen costs increase due to serving a higher percentage of COVID-19 positive individuals. Given that health plans receive a fixed amount per month based on historical utilization and trends, the uncertainty of COVID-19 has resulted in states wanting to better manage what is occurring within health plan capitation funding. To that end, states spoke to using some of the flexibilities offered by CMS to redirect funds. For instance, Virginia worked with health plans to allocate additional dollars to nursing facilities and other providers out of the existing capitation rates. The state used this targeted approach to increase support to more impacted providers while pulling savings from changes in utilization. States have also been more active in placing risk corridor protections in contracts to limit overall health plan profitability.

State Medicaid agencies should evaluate opportunities to implement measures to ensure resources are available to address provider viability and overall access for members. This requires states to work with providers, health plan actuaries, and data teams to pull relevant information. Ultimately it may require Medicaid contractual changes to implement these financing strategies.

- **State Medicaid Agencies** can conduct analyses to determine if they can re-direct resources through contractual changes, within the existing capitation rates, to providers seeing a high volume of COVID-19 patients. Some states have been doing this through directed payments.

  States can implement risk corridors to address current utilization uncertainty and ensure appropriate fiduciary oversight of Medicaid resources.

  To further improve efficiency of limited public dollars, states can put additional requirements on health plans and providers to enter into value-based purchasing agreements and move away from fee-for-service arrangements. As telehealth and telemedicine services expand, compensating providers based on value over volume of services will be even more critical.

- **Health Plans** can help collect and share information with states regarding key provider types that are experiencing challenges related to COVID-19 and recommend opportunities to support these providers. Plans can also continue to expand their value-based programs and develop specific programs to ensure quality care is delivered through telehealth and telemedicine services.

Conclusion

State Medicaid programs and health plans that align Medicare and Medicaid functions, both clinical and financial, have diverse infrastructure in place that enhances their ability to immediately respond to the needs of their vulnerable dually eligible members. Responding to the needs of dually eligible individuals during the COVID-19 pandemic requires a thoughtful approach that identifies strengths within existing programs and policies that facilitate an appropriate response. It also requires identification of opportunities to refine policies and develop new programs to appropriately meet heightened medical and social needs. States and plans can continue to improve response efforts and prepare for future infectious disease outbreaks through implementation of a variety of requirements and strategies that improve the infrastructure serving dually eligible individuals.

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ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

ABOUT SPEIRE HEALTHCARE STRATEGIES

Speire Healthcare Strategies is a boutique health care consulting firm providing strategic advisory services at the intersection of policy and strategy. Blending years of consulting and government experience with extensive industry knowledge and relationships, we help our clients navigate the changing healthcare landscape and develop high quality. For more information, visit **speirehcs.com**.

Appendix. Key Characteristics of Interviewees

Interviewed State Departments

State Department	Integrated Models
Minnesota Department of Human Services	Minnesota has among the longest-standing integrated programs for dually eligible individuals in the country with two Medicaid managed care programs for seniors and one for individuals with disabilities. The Minnesota Senior Health Options (MSHO) is a voluntary FIDE-SNP program. All other seniors who do not choose MSHO are enrolled in Minnesota Senior Care Plus (MSC+) for Medicaid health care and LTSS. Special Needs BasicCare (SNBC) is a voluntary Medicaid MC program for adults 18-64 with disabilities. Eligible individuals are automatically enrolled in SNBC unless they opt out. Some SNBC plans also have an integrated HIDE-SNP for those who are duals.
Virginia Department of Medical Assistance Services	In 2018, Virginia launched its MLTSS/D-SNP program called the Commonwealth Coordinated Care Plus (CCC Plus) program that includes medical services, nursing and personal care, and behavioral (mental) health services in one plan. As the program evolves, the state is strengthening requirements to ensure only D-SNPs that offer an MLTSS plan can operate in the state and that all MLTSS plans offer a D-SNP product in overlapping geographical regions to promote enrolled alignment.

Interviewed Health Plans

Health Plan	Products	State(s)	Population Sizes
Centene	▪ D-SNPs ▪ FIDE-SNPs ▪ MMPs ▪ MLTSS	▪ D-SNP: 31 States ▪ FIDE-SNP: 2 States (NJ, NY) ▪ MMP: 6 States (CA, IL, MI. OH, SC, TX) ▪ MLTSS: 13 States (AR, CA, FL, HI, IA, IL, KS, NM, NY, NJ, OH, PA, TX)	▪ D-SNP: 188,000 ▪ FIDE-SNP: 46,000 ▪ MMP: 59,000 ▪ Duals in Medicaid MLTSS Product: 243,000
iCare	▪ D-SNP ▪ FIDE-SNP	▪ Wisconsin	▪ D-SNP: 7,997 ▪ FIDE-SNP: 718 ▪ MLTSS Medicaid-only: 429
Mercy Care	▪ D-SNP ▪ FIDE-SNP	▪ Arizona	▪ D-SNP: 11,372 ▪ FIDE-SNP: 4,972
Molina	▪ D-SNPs ▪ FIDE-SNP ▪ MMPs	▪ CA, FL, ID, IL, MI, NM, OH, SC, TX, UT, WA, WI	▪ D-SNP: 41,866 ▪ FIDE-SNP: 2,792 ▪ MMP: 61,568
UPMC	▪ D-SNP ▪ MLTSS	▪ Pennsylvania	▪ D-SNP: 25,897 ▪ MLTSS: 42,000
VNSNY CHOICE	▪ FIDE-SNP ▪ MLTSS	▪ New York	▪ FIDE-SNP: 3,079 ▪ Duals in Medicaid MLTSS: 17,454

ENDNOTES

[1] Interviews were conducted with Medicaid agency officials in Minnesota and Virginia, as well as health plan staff from Centene, iCare, Mercy Care, Molina, UPMC, and VNSNY CHOICE. Please see the acknowledgments for a full list of contributors.

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[20] The Bipartisan Budget Act of 2018 permanently authorized D-SNPs. It also included the addition of new minimum integration standards for all D-SNPs. Beginning January 1, 2021, all D-SNPs must either cover Medicaid long-term services and supports and/or behavioral health services or communicate information on certain high-risk members' hospital and skilled nursing facility admissions to a designated entity. Additional requirements were also added formalizing basic care coordination responsibilities of D-SNPs to coordinate Medicaid benefits of their dually eligible members regardless of Medicaid source of coverage.

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