Mercer

Government Human Services Consulting

Nevada Dual-Special Needs Plan Report

State of Nevada

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Contents

Section 1

Executive Summary

The state of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) retained Mercer Government Human Services Consulting (Mercer), part of Mercer Health and Benefits LLC, in April 2023 to provide technical support to evaluate options for advancing Medicare and Medicaid integration for current and future Medicare Dual Special Needs Plans (D-SNPs). This evaluation includes national best practices and state program specific research and client discussion sessions. The development of this document was toward a final report summarizing the most current practices and recommended considerations for Nevada. The intended outcome of these efforts was to provide insights that could contribute to new policy development, inspire network management initiatives, and lead to enhancements of the current contracts that would promote high-quality outcomes, well-integrated benefits and services, and accessible care and services for all dual-eligible members in Nevada.

Numerous reputable national resources were accessed to gather research content, including Commission, Centers for Medicare & Medicaid Services (CMS), Kaiser Family Foundation, National Committee for Quality Assurance (NCQA), and the US Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE). The current contract template used by Nevada with its D-SNPs was reviewed, as well as the associated website of each currently contracted D-SNP, to understand both the content and overall quality of publicly shared information for enrollees and members.

Nevada operates a coordination-only approach with its D-SNPs and is exploring options to better integrate services for this population. Nevada requires basic benefit coverage from D-SNPs, consistent with national standards and national plan practices. Alignment of D-SNP benefits with Medicaid plan services is encouraged through adding specific contractual language, including quality metrics, to promote plan performance and should be a primary consideration.

The D-SNP market is growing rapidly across the county, with potential risk of saturation and confusion for enrollees as a possible outcome if not managed. Nevada currently contracts with eight D-SNPs, with an additional plan anticipated to become available in January 2024. Although the diversity of the state's network continues to grow, most enrollments are held by only three of the eight plans. In addition, review of star ratings, quality measures, and initial CMS model of care (MOC) reviews indicated that the highest enrolled plan illustrates lower quality in some areas compared to competitors. They also illustrate that coverage is predominantly in urban regions across Nevada, with disparities in rural regions of the state. Furthermore, supplemental benefit options vary widely among Nevada's current plans.

Several suggested approaches for the state's consideration are highlighted within this paper, including limiting enrollment in D-SNPs to fully dual-eligible beneficiaries, using a population phased-in approach, and contractually requiring plans to report quality and performance outcome details. Additional and ongoing study of utilization of the supplemental benefit across the current plans could help Nevada understand the importance of these services and, in turn, help with future decisions regarding network and benefits. If the state has the goal of providing integrated, high-quality benefits, services, and care, further and ongoing analysis of single parent Medicare-Medicaid Plans (MMPs) is needed.

Section 2
Introduction

Dual-special needs plans (D-SNPs) are types of Medicare Advantage plans that only enroll individuals who are entitled to both Medicare and state plan Medicaid coverage. Nationally, the first plan examples were operationalized in 2006, serving individuals who qualify for both types of coverage and who are often a high-needs population.[1] These individuals may have complex physical and behavioral health conditions, requiring well-coordinated and aligned care and support from diverse and specialized providers.[2]

Regrettably, Medicare and Medicaid programs and regulations are often misaligned, which may lead to confusion and duplicative actions for people served. This misalignment also increases administrative burden for payers and providers and creates challenges for state governments seeking to monitor compliance and quality outcomes. The purpose of the D-SNP model is to address this misalignment and encourage collaborative administrative practices, care coordination, and streamlined information and education for individuals served by both programs (referred to as “dual eligibles”).

All carriers offering D-SNPs must apply for and obtain a contract with the federal Centers for Medicare & Medicaid Services (CMS) and must hold state-specific Medicaid agency contracts (SMACs) with each state in which they operate. States are not required to contract with carriers offering D-SNPs and have the authority to deny contracting with potential D-SNPs.[3]

Currently in Nevada, the Division of Health Care Financing and Policy (DHCFP), which is housed within the Department of Health and Human Services, holds SMACs with eight D-SNP carriers.

The research for this document was conducted in 2023, and narrative content was revised in 2024.

[1] “Definitions of Different Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Types in 2023 and 2025,” available at https://www.integratedcareresourcecenter.com/sites/default/files/ICRC-D-SNPDefinitions-2023-2025%20%284%29.pdf.

[2] “Integrating Care through Dual Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges,” available at https://aspe.hhs.gov/reports/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-challenges-0.

[3] “Selectively Contracting with D-SNPs to Promote Alignment with Medicaid Managed Care Plans,” available at https://www.integratedcareresourcecenter.com/sites/default/files/D-SNP%20Selective%20Contracting%20Webinar%20slides%20FINAL%202-23-23.pdf.

Section 3

Purpose/Methodology

The DHCFP contracted with Mercer to provide technical support in evaluating options for advancing Medicare and Medicaid integration for D-SNPs and options for Nevada's dual-eligible population.

Phase One of this project included a review of national research of other state D-SNP programs and an analysis of Nevada's current landscape of coverage and services that are offered to dual-eligible beneficiaries. This review and research culminated in a list of suggested policy options as described in this report. The policy options in this report were informed by national research, information specific to the landscape in Nevada, and best practices.

Mercer used a standardized research template to identify features of D-SNPs as part of the national research. A standard research template was also used to document information regarding the Nevada-specific research, including information on each individual D-SNP plan. The research in this report relied on information from the Integrated Care Resource Center,[4] an initiative of the CMS Medicare-Medicaid Coordination Office. Through the national research comparison with the Nevada-specific information, Mercer identified key policy options for the DHCFP's consideration.

[4] Integrated Care Resource Center. "About Us," available at https://www.integratedcareresourcecenter.com/about-us.

Section 4
National D-SNP Analysis

Overview

Mercer completed a national environmental scan of a variety of D-SNP programs and policies. The research targeted states that have a combination of Medicaid managed care and fee-for-service (FFS) delivery systems. Mercer examined promising practices in other states, SMAC strategies, state oversight functions, and key operational elements of D-SNP programs. Mercer leveraged information from the Integrated Care Resource Center and The Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC).

The summary below includes certain strategies that states may use within the SMAC, a comparison of D-SNP programs across the country, integration status, information regarding enrollment, network, care coordination, and supplemental benefits, as well as details on state information-sharing models and practices. The states reviewed were selected based on accessible information, which allowed for an objective study of D-SNPs and their various comparative aspects. This research seeks to provide insights and options for Nevada to consider when planning next steps for improving its D-SNP programs.

State Comparison and National Analysis of D-SNPs

Often dual-eligible beneficiaries, covered by both Medicaid and Medicare, can experience fragmented care, poor coordination of services, and poor health outcomes.[5] The goal of D-SNPs is to help address this fragmentation by promoting increased integration between Medicare and Medicaid plans and benefits. The expectation is that having Medicaid and Medicare plans under one parent company will allow for shared platforms, policies, staff, and operations, all of which should help coordinate care, services, and benefits with less obstacles as compared to these plans being managed by two separate parent companies and programs.

SMAC Requirements, Strategies for Integration, and Delivery Systems

Per federal law, the SMAC required elements that states must include as well as optional elements that states can choose to include. The mandatory elements include:[6]

- The Medicare Advantage organization's responsibilities — including financial obligations — to provide or arrange for Medicaid benefits
- Categories of eligibility for dually eligible beneficiaries to be enrolled under the D-SNP, including the targeting of specific subsets

[5] MACPAC. "Chapter 6: Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans," available at https://macpac.gov/wp-content/uploads/2021/06/Chapter-6-Improving-Integration-for-Dually-Eligible-Beneficiaries-Strategies-for-State-Contracts-with-Dual-Eligible-Special.pdf.

[6] MACPAC. "Medicare Advantage dual eligible special needs plans," available at https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/.

- Medicaid benefits covered under the D-SNP
- Cost-sharing protections covered under the D-SNP
- Information about Medicaid provider participation and how that information is to be shared
- Verification process of an enrollee's eligibility for both Medicare and Medicaid
- Service area covered under the D-SNP
- Period of the contract

The above elements of SMACs do not necessarily result in integrated care. Therefore, states can also use a variety of additional strategies in their SMAC with D-SNPs to improve integration. Twenty-nine states have added integration requirements into their D-SNP contracts.[7]

Table 1 depicts SMAC strategies that all states can use and strategies managed care states can use.

Table 1: SMAC Strategies[8]

Who Can Utilize Strategy	SMAC Strategy
All states can use	1. Limit D-SNP enrollment to full-benefit dually eligible beneficiaries. 2. Contract directly with D-SNPs to cover Medicaid benefits. 3. Require D-SNPs to use specific or enhanced care coordination methods. 4. Require D-SNPs to send data or reports for state oversight purposes. 5. Require state review of D-SNP materials related to delivery of Medicaid benefits. 6. Partner with D-SNPs to develop supplemental benefit packages that compliment Medicaid benefits.
States with managed care can use	7. Selectively contract with D-SNPs or Medicaid managed care plans that offer aligned plans. 8. Require complete service area alignment. 9. Allow or require D-SNPs to operate with exclusively aligned enrollment. 10. Allow or require D-SNPs to use default enrollment. 11. Automatically assign D-SNP enrollees to Medicaid plans under the same parent organization. 12. Incorporate Medicaid quality improvement priorities into the SMAC. 13. Automate Medicaid crossover claims payment processes for payment of Medicare cost sharing.

[7] Kaiser Family Foundation. "Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals," available at https://www.kff.org/medicaid/issue-brief/medicaid-arrangements-to-coordinate-medicare-and-medicaid-for-dual-eligible-individuals/.

[8] MACPAC. "Chapter 6: Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans," available at https://macpac.gov/wp-content/uploads/2021/06/Chapter-6-Improving-Integration-for-Dually-Eligible-Beneficiaries-Strategies-for-State-Contracts-with-Dual-Eligible-Special.pdf.

Table 2 depicts three distinct options for integrating Medicare and Medicaid services and programs. States may choose to what degree they wish to integrate their programs.

Table 2: D-SNP Integration

Type of D-SNPs	Description
Coordination Only *37 states	Provide Medicare-covered services and are required to coordinate the delivery of benefits with Medicaid programs, contract with the state Medicaid program, and conduct particular information sharing.[9]
Highly Integrated (HIDE) *12 states	Feature a moderate level of coordination and integration[10] in which the plans must also have a Medicaid plan operating in the same counties as the D-SNP, but there is no requirement that individuals enroll in both plans.[11] The D-SNP must meet the requirements of coordination-only D-SNPs.[12]
Fully Integrated (FIDE) *18 states	Fully integrated care for dually eligible beneficiaries under a single managed care organization (MCO) and must offer an aligned Medicaid plan that integrates Medicare and Medicaid benefits.[13, 14] FIDE D-SNPs represent the most integrated level of coordination and must meet the requirements of coordination-only D-SNPs.

*Per 2022 CMS Data.[15]

In addition to D-SNPs, states also choose to support dually eligible beneficiaries through other programs such as Program of All-Inclusive Care for the Elderly (PACE) and Financial Alignment Initiative (FAI). PACE programs provide comprehensive medical and social services to individuals who are 55 years of age or older and need a nursing home level of care but are able to live safely in the community, most of whom are dually eligible for Medicare and Medicaid benefits.[16] An interdisciplinary team provides PACE participants with coordinated care.[17] FAI is a FFS model demonstration, a state and federal option to enroll dual-eligible beneficiaries into Medicaid and Medicare programs that cover primary, acute, behavioral health, and long-term supports and services (LTSS).[18] FAI allowed states to test new models for improving coordinated care, most often by a Medicare-Medicaid joint single

[9] Kaiser Family Foundation. "Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals," available at https://www.kff.org/medicaid/issue-brief/medicaid-arrangements-to-coordinate-medicare-and-medicaid-for-dual-eligible-individuals/.

[10] MACPAC. "Chapter 6: Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans," available at https://macpac.gov/wp-content/uploads/2021/06/Chapter-6-Improving-Integration-for-Dually-Eligible-Beneficiaries-Strategies-for-State-Contracts-with-Dual-Eligible-Special.pdf.

[11] Kaiser Family Foundation. "Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals," available at https://www.kff.org/medicaid/issue-brief/medicaid-arrangements-to-coordinate-medicare-and-medicaid-for-dual-eligible-individuals/.

[12] Ibid.

[13] MACPAC. "Medicare Advantage dual eligible special needs plans," available at https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-.

[14] Kaiser Family Foundation. "Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals," available at https://www.kff.org/medicaid/issue-brief/medicaid-arrangements-to-coordinate-medicare-and-medicaid-for-dual-eligible-individuals/.

[15] Ibid.

[16] Ibid.

[17] Medicaid.gov Keeping America Healthy. "Program for All-Inclusive Care for the Elderly," available at https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html#:~:text=The%20Programs%20of%20All-Inclusive,for%20Medicare%20and%20Medicaid%20benefits.

[18] Integrated Care Resource Center. "Working with Medicare Medicare 201: Actions States Can Take to Improve Quality and Coordination of Care for Dually Eligible Individuals," available at https://www.integratedcareresourcecenter.com/sites/default/files/WWM%20201%20Slide%20Deck_%20for%20508.pdf.

health plan, a three-way contract between the state, federal government, and a health plan.[19] CMS intends to end this model by December 2025 and transition those plans to D-SNPs.

Table 3 depicts a variety of D-SNP elements in states across the country, including delivery systems (managed care), FAI, levels of integration, PACE, and SMAC strategies (defined in Table 1).[20]

Table 3: State Comparison of D-SNPs[21]

State	Managed Care	FAI	FIDE	HIDE	Coordination Only	PACE	SMAC Strategies* (corresponding to strategies defined in Table 1 – strategies 1–6 are available to all states, strategies 7–13 are available to managed care states)
Alabama					x	x	2
Arizona	x		x	X			1, 4, 6, 7, 8, 10
Arkansas	x				x	x	
California	x	x	x		x	x	
Colorado	x			X		x	
Connecticut					x		
Delaware	x				x	x	
District of Columbia	x			x			
Florida	x		x	x	x	x	2
Georgia					x		
Hawaii	x			x			1, 6
Idaho	x		x		x		1, 2, 3, 5, 9
Illinois	x	x					
Indiana					x	x	
Iowa	x				x	x	
Kansas	x			x		x	
Kentucky	x			x	x		10
Louisiana					x	x	

[19] Kaiser Family Foundation. "Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals," available at https://www.kff.org/medicaid/issue-brief/medicaid-arrangements-to-coordinate-medicare-and-medicaid-for-dual-eligible-individuals/.

[20] MACPAC. "Chapter 6: Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans," available at https://macpac.gov/wp-content/uploads/2021/06/Chapter-6-Improving-Integration-for-Dually-Eligible-Beneficiaries-Strategies-for-State-Contracts-with-Dual-Eligible-Special.pdf.

[21] Kaiser Family Foundation. "Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals," available at https://www.kff.org/medicaid/issue-brief/medicaid-arrangements-to-coordinate-medicare-and-medicaid-for-dual-eligible-individuals/.

State	Managed Care	FAI	FIDE	HIDE	Coordination Only	PACE	SMAC Strategies* (corresponding to strategies defined in Table 1 – strategies 1–6 are available to all states, strategies 7–13 are available to managed care states)
Maine					x		
Maryland					x	x	
Massachusetts	x	x	x			x	1, 3, 4, 5, 9
Michigan	x	x			x	x	
Minnesota	x	x	x	x			1, 3, 4, 5, 9, 11, 12
Mississippi					x		
Missouri					x		
Montana					x		
Nebraska	x			x	x	x	
New Hampshire	x						
New Jersey	x		x			x	1, 5, 6, 8, 9, 11
New Mexico	x			x		x	
New York	x	x	x	x	x	x	10
North Carolina				x	x	x	
North Dakota						x	
Ohio		x			x	x	
Oklahoma					x	x	
Oregon	x			x	x	x	4, 10
Pennsylvania	x		x	x	x	x	10
Rhode Island		x			x	x	
South Carolina		x			x	x	
South Dakota					x		
Tennessee	x		x	x	x	x	5, 7, 10
Texas	x	x		x	x	x	
Utah	x				x		10
Virginia	x		x	x	x	x	7, 10

State	Managed Care	FAI	FIDE	HIDE	Coordination Only	PACE	SMAC Strategies* (corresponding to strategies defined in Table 1 – strategies 1–6 are available to all states, strategies 7–13 are available to managed care states)
Washington		x		x	x	x	
West Virginia					x		
Wisconsin	x		x	x		x	
Wyoming					x		

*There were no details specific to Alaska in the data sources cited.

Enrollment

Aligned enrollment is one way to further integrate care in which the member is enrolled in a D-SNP and MCO that is offered by the same parent company in the same geographic area.[22] States have a variety of strategies they can use regarding enrollment to promote alignment. Enrollment can be targeted using SMAC strategies illustrated in Table 1 and through other opportunities.

To maximize enrollment in aligned plan options, states can focus enrollment choices on alignment and integration of benefits, maximize integration through auto-assignments, promote aligned enrollment through marketing, and engage enrollment counselors.[23] Aligned enrollment allows one entity to be responsible for both Medicare and Medicaid benefits. It can be simpler for beneficiaries and providers, as well as provide a better opportunity for care coordination to support beneficiaries across their Medicare and Medicaid benefits.[24]

States can also use age requirements for D-SNP enrollees to support the integration of care.[25] In Idaho, D-SNP enrollees must be age 21 years or older.[26] In Massachusetts, D-SNP enrollees must be 65 years or older, but those in Medicare-Medicaid Plans (MMPs) can be younger than 65 years.[27] In Minnesota, enrollees must be 65 years or older, but there are separate D-SNPs/managed care plans for those younger than 65 years.[28] States use age requirements to enroll specific populations. For example, a state limiting enrollment to the over 65 years population could do so to retain FFS delivery systems for younger populations and individuals with disabilities.[29]

Networks

CMS considers three measures of network adequacy: (1) minimum number of providers by type, (2) maximum travel distance to providers and facilities, and (3) maximum travel time to

[22] Integrated Care Resource Center. "Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations," available at https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_InfoSharing_HospitalSNF%20082819.pdf.

[23] Ibid.

[24] Ibid.

[25] Ibid.

[26] Ibid.

[27] Ibid.

[28] Ibid.

[29] Ibid.

providers/facilities within the service area. For a contract to pass, each county must meet at least a 90% threshold for each of these three standards.

Network adequacy standards for Medicaid managed care plans differ by state. In 2016, CMS required[30] states to establish time and distance standards for specific types of providers, but this ended effective December 2020; instead, allowing states to establish any type of quantitative network adequacy standard. CMS is currently developing a "comprehensive access strategy" across Medicaid FFS and managed care delivery systems, with a notice of proposed rulemaking planned for October 2022.[31]

Based on the ability to currently establish some network guidelines for measuring adequacy, states can consider rural areas in comparison to metro areas and adjust network guidelines for these areas appropriately. Standards for provider-to-member ratios vary by state and should consider geographical differences. Wait times are strongly associated with provider shortages, especially in rural areas.

State standards should be reviewed annually by the state, with requirements for submission from health plan entities to ensure compliance with such standards.

Care Coordination

States can take a variety of approaches to care coordination for D-SNP beneficiaries. States can require D-SNPs to implement state-specific provisions aimed at better coordinating Medicaid and Medicare.[32] States can do this by specifying certain care coordination requirements within the SMAC and/or specifying in the SMAC that the D-SNP must include certain content within its model of care (MOC).[33] Further, states can require D-SNPs to submit their MOCs to the state for review.[34] The Integrated Care Resource Center outlines five key elements of care coordination: health risk assessments (HRAs), care management and planning, managing care transitions, addressing social needs, and information technology, data, and reporting.[35]

The Integrated Care Resource Center encourages states to consider the following regarding care coordination: aligning timelines, delivery systems, and state oversight and resource needs.[36] Additionally, states can require D-SNPs to contract and/or coordinate with other community-based organizations or require D-SNPs to coordinate with health homes, home- and community-based services (HCBS) waiver programs, and other providers.[37] These efforts can support overall coordination between Medicaid and Medicare as well as care coordination for the member.

[30] "CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions," available at https://www.kff.org/medicaid/issue-brief/cmss-final-rule-on-medicaid-managed-care-a-summary-of-major-provisions/.

[31] "View Rule," available at https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202110&RIN=0938-AU68.

[32] Integrated Care Resource Center. "Leveraging the Dual Eligible Special Need Plan (D-SNP) Model of Care to Enhance Enrollee Care Coordination," available at https://www.integratedcareresourcecenter.com/sites/default/files/ICRC%20D-SNP%20Care%20Coordination%20Webinar_FINAL_updated%2004242023.pdf.

[33] Ibid.

[34] Ibid.

[35] Ibid.

[36] Ibid.

[37] Ibid.

Essentially, the care coordination services can make the benefits and associated networks work as seamlessly as possible for the member, from a navigation and transition perspective, to comply with requirements and member needs for the best member experience and quality outcomes.

A staffing consideration for the number of care coordinators per member (staff-to-member ratio) is essential to the outcome that may be a required element for state review/approval. States can consider transition of care for members that involves members that are transitional between levels and settings of care that require critical care coordination for successful member outcomes. LTSS, behavioral health, and social determinants of health are all areas for which states should consider requirements for D-SNP and Medicare collaboration of information, staff training and education, and may even include required contracting with community organizations to achieve such collaboration. State oversight of such collaboration should be considered through required tracking, trending, and reporting of member outcomes.

Information Sharing

CMS final rule (2019) requires SMACs to specify a process to share information with the state or state's designee (such as Medicaid MCO or Medicaid care manager) on hospital and skilled nursing facility (SNF) admissions of high-risk individuals enrolled in D-SNP.[38] States can define their own role in the information sharing, including being directly involved or delaying responsibility to D-SNPs and providers for the collection and exchange of data.[39]

States with MCOs and FFS can consider which providers or entities in the FFS system should receive inpatient and SNF admission information. This can be achieved by the state initially receiving the data and passing it along to the appropriate entities, or states can arrange for D-SNPs to share the data directly with providers.[40]

The Integrated Care Resource Center identifies three main approaches to information sharing:[41]

1. Event notification solutions that can be leveraged by D-SNPs, states, Medicaid plans, and providers
2. State portal for collecting and disseminating information sharing
3. Plan- and provider-developed processes for sharing information

State examples of these approaches include Oregon, Pennsylvania, and Tennessee.

[38] Integrated Care Resource Center. "Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations," available at https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_InfoSharing_HospitalSNF%20082819.pdf.

[39] Ibid.

[40] Ibid.

[41] Ibid.

Table 4: Examples of State Information-Sharing Approaches

State	Information-Sharing Approach
Oregon	• Event Notification System (ENS): — Emergency department information exchange (EDIE) — Collective platform (web portal)
Pennsylvania	• Plan-Driven Approach: — State requires plans to collaborate in information-sharing practices
Tennessee	• State-Driven Approach: — Specific requirements of D-SNPs to share information

Section 5
Covered Services

National Approach to Benefits

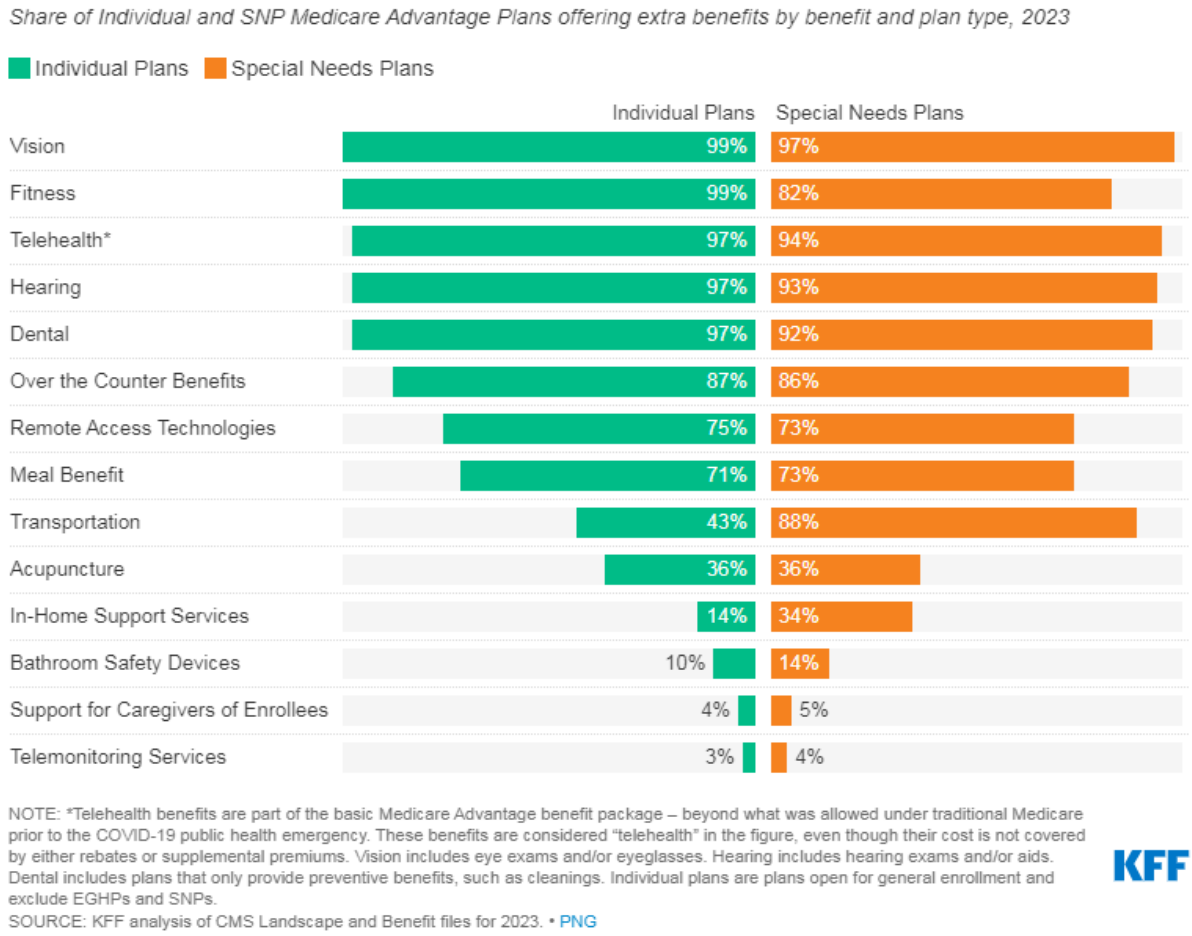
As described above in the national analysis of D-SNPs, SNPs and D-SNPs serve a high needs population and can offer unique benefits beyond what is typically covered by Medicare. A SNP is a type of Medicare Advantage plan. Other types of SNPs include Chronic Condition Special Needs Plans (C-SNPs) and Institutional Special Needs Plans (I-SNPs).[42] Table 5 is a high-level summary of the differences between SNPs and D-SNPs. States take a variety of approaches to the required benefits that SNPs and D-SNPs must offer. Figure 1 below illustrates benefit offerings from Medicare Advantage plans across the country, although SNPs are not specific to D-SNPs.

Table 5: Differences between D-SNPs and SNPs

Feature	Special Needs Plans (SNPs)[43]	Dual-Special Needs Plans (D-SNPs)[44]
Targeted Population	Caters to three groups: D-SNPs, C-SNPs, and I-SNPs	Specifically designed for individuals eligible for both Medicare and Medicaid
Benefits and Services	Offers benefits tailored to the special groups they serve	Provides coordinated care across Medicare and Medicaid, prescription drug coverage, and potentially additional benefits such as dental and vision care
Care Coordination	Provides care coordination with varying levels and intensity	Strong focus on care coordination due to the complex needs of members. Often include care management services
Eligibility Criteria	Medicare Part A and Part B, live in plan's service area, meet specific eligibility for the type of SNP	Specific income and asset requirements for dual coverage under Medicare and Medicaid
Enrollment Process	Varies based on the type of SNP	Varies by state and individual circumstances; includes eligibility for both Medicare and Medicaid

[42] "Special Needs Plans," available at https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans.
[43] "Special Needs Plans (SNP)," available at
[44] "Dual Eligible Special Needs Plans (D-SNPs)," available at

Figure 1: National Medicare Advantage Offerings[45]



States can require SNPs and D-SNPs to offer specific benefits as standard benefits, such as vision and dental, to more supplemental offerings such as described below in the Supplemental Benefits section of this paper.

Nevada D-SNP Benefits

Nevada has chosen to make eight services available for D-SNP recipients and required for each D-SNP to provide.[46] This includes:

- Dental
- Vision
- Hearing aids
- Non-emergency transportation to and from medical visits, including pharmacy

[45] Kaiser Family Foundation. "Medicare Advantage 2023 Spotlight: First Look," available at https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/#Plan%20Offerings%20in%202023.

[46] Nevada Department of Health and Human Services DHCFP. "Dual Eligible Special Needs Program (D-SNP)," available at https://dhcfp.nv.gov/Pgms/DSNP/Dual_Eligible_Special_Needs_Plans_(D-SNP)/.

- Personal Emergency Response Systems
- Nursing hotline
- Telemedicine
- Meal services after a hospital stay

The following benefits are available in some state plans nationally, and are reflected in Figure 1, but are not required in Nevada as D-SNP standard benefits:

- Fitness
- Remote access technology
- Over the counter
- Acupuncture
- In-home support services
- Bathroom safety devices
- Support for caregivers
- Telemonitoring

Analysis of supplemental benefits offered by D-SNPs across the country is below. Section 5 and Section 6 of this paper include additional details regarding Nevada-specific plans.

Supplemental Benefits

States have various opportunities to coordinate with D-SNPs regarding supplemental benefit offerings. D-SNP supplemental benefits cannot duplicate benefits offered to dually eligible individuals through state Medicaid programs.[47] Supplemental benefits can be used to fill gaps in existing Medicaid coverage, overcome barriers to accessing HCBS, address social needs, and reduce avoidable costs.[48] Examples of supplemental benefits include adult day health, support for caregivers, home-based palliative care, and bathroom safety devices.[49] States can also target benefits to people with chronic illnesses (Special Supplemental Benefits for the Chronically Ill [SSBCI]), including structural home modifications, pest control, respite, and groceries.[50] As SNPs serve a high-need population, many provide additional benefits such as transportation benefits (88%), in-home support services (34%), support for caregivers (5%), and telemonitoring services (4%).[51]

[47] Integrated Care Resource Center. " Working with Medicare Medicare 201: Actions States Can Take to Improve Quality and Coordination of Care for Dually Eligible Individuals," available at https://www.integratedcareresourcecenter.com/sites/default/files/WWM%20201%20Slide%20Deck_%20for%20508.pdf.

[48] Ibid.

[49] Ibid.

[50] Ibid.

[51] Kaiser Family Foundation. "Medicare Advantage 2023 Spotlight: First Look," available at https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/#Plan%20Offerings%20in%202023.

Table 6: State Approaches to Supplemental Benefits[52]

State	State Requirements for Supplemental Benefits[53]
Arizona	• Plans have flexibility to design benefit packages • Encourages plans to propose innovative supplemental benefits, including SSBCI
Minnesota	• D-SNPs must submit data to state actuary to ensure that benefits are billed correctly • Discuss how supplemental benefits fit into the larger benefit package at annual meetings between the D-SNP and the state
Pennsylvania	• D-SNPs must offer at least one supplemental benefit that fills a gap in Medicaid services • D-SNPs must submit a list of supplemental benefits to the state. • Quarterly meetings with the state and the D-SNP to discuss a variety of topics, including benefits

[52] Integrated Care Resource Center. "Working with Medicare Medicare 201: Actions States Can Take to Improve Quality and Coordination of Care for Dually Eligible Individuals," available at https://www.integratedcareresourcecenter.com/sites/default/files/WWM%20201%20Slide%20Deck_%20for%20508.pdf.

[53] Ibid.

Section 6
Nevada D-SNP Plan Analysis

Overview

Nevada currently contracts with eight Medicare Advantage plans. These include Aetna, Alignment Healthcare (Alignment), Allwell via Centene corporation, Anthem, Hometown Health (Hometown) via Renown Health, Humana, Molina Healthcare (Molina), and United Healthcare (United). In addition to the national scan and best practices research and analysis, Mercer collected and reviewed information about these eight plans to understand current operations and future opportunities. Information was also reviewed regarding Prominence Health Plan (Prominence), whose contract will not begin in Nevada until January 2024.

Materials reviewed included those available through publicly facing resources such as CMS published reports (e.g., 2023 Medicare Advantage Star Ratings[54], MOC scores from the National Committee on Quality Assurance [NCQA][55]), plan websites, and other information provided by DHCFP.

Mercer considered three areas in its Nevada D-SNP plan research:

- Enrollment and territory:
  - Total member enrollment as of July 2023 (Figure 2)
  - Counties served in Nevada (urban versus non-urban) (Table 7)
- Experience and quality:
  - Experience operating as a FIDE, HIDE, or Managed Long-Term Services and Supports (MLTSS) D-SNP in other states (Table 8)
  - Total score from most current CMS MOC review (Table 9)
  - Available Medicare Advantage Star Ratings look-back (2023 and 2022 scores) (Table 10)
- Supplemental benefits:
  - Available detail regarding supplemental benefits offered (Table 11)

Some plans had incomplete information or unavailable information due to their limited tenure operating as an approved plan within Nevada or with CMS. Planned to begin service in January 2024, Prominence information was included even though the plan is not currently serving members in Nevada. The tables below illustrate the comparison among the plans. Table 12 shows a comparison among the contracted plans across all areas.

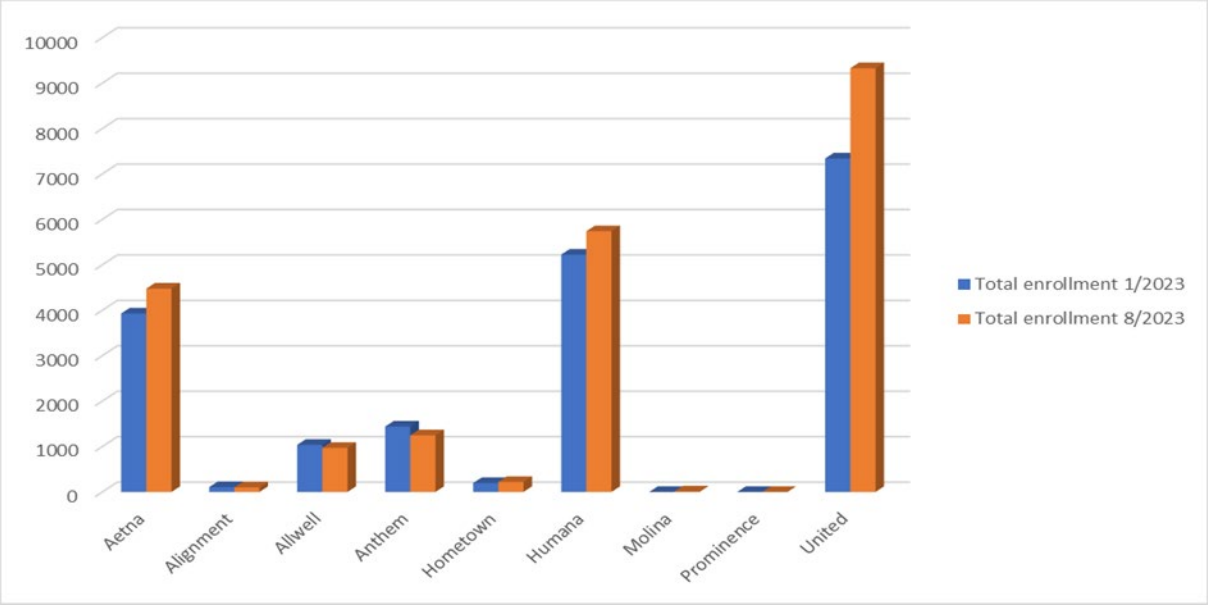
[54] CMS. "2023 Medicare Advantage and Part D Star Ratings," available at https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings.

[55] "Model of Care Scores," available at https://snpmoc.ncqa.org/.

Nevada D-SNP Enrollment and Territory

Nevada has over 94,000 people who are dually eligible for both Medicaid and Medicare coverage.[56] Currently, Nevada has chosen three dual-eligible categories to participate in D-SNPs, including full-benefit dual eligible, qualified Medicare beneficiary, and qualified Medicare beneficiary plus.[57] The combined total enrollment from these eligible groups into D-SNPs as of August 2023 was 22,094 individuals. Three D-SNPs accounted for 88% of Nevada's total enrolled beneficiaries. United has the highest enrollment (9,328 individuals), representing 42% of the state's total D-SNP enrollment. Figure 2 below shows additional detail regarding enrollment across the currently contracted plans from January 2023 to August 2023.

Figure 2: Nevada D-SNP Enrollment August 2023[58]



Nevada is composed of 16 counties and one municipality, Carson City, the state's capitol, that, in total, account for 17 different regions across the state. Eighty-eight percent of the total dually eligible Nevadans live in two urban counties, Clark and Washoe,[59] where the largest service penetration occurs among the contracted plans. Although United has the highest percentage of enrollment in Nevada, it is currently only serving people in Clark, Washoe, and Nye counties; whereas, the two other high-enrollment plans, Aetna and Humana, have enrolled members in six and seven rural counties, respectively, as well as Clark and Washoe. Much of the Nevada landscape is rural, and seven counties are not receiving any D-SNP services from the state's eight currently contracted plans.

In Table 7, yellow highlights indicate plans in which service is provided in urban and multiple rural counties.

[56] "Overview of Nevada's Dual Special Needs Plan Program," available at https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/MeetingArchive/Workshops/2023/PW_08-23-23_DSNP_Stakeholder_Meeting_Presentation.pdf.

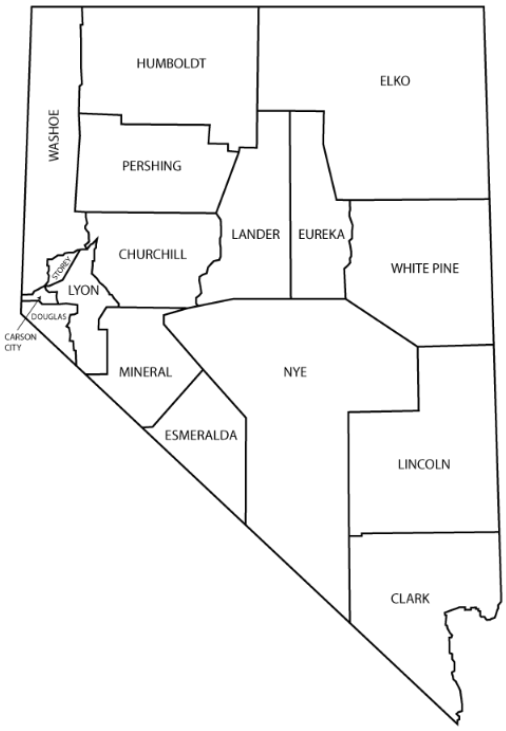
[57] Dual Eligible Special Needs Program (D-SNP)," available at https://dhcfp.nv.gov/Pgms/DSNP/Dual_Eligible_Special_Needs_Plans_(D-SNP)/.

[58] NV DHCFP Report.

[59] "Nevada Medicaid Operations," available at https://app.powerbigov.us/view?r=eyJrIjoiZGQ0NTE5ZmUtYjAxNi00NjQzLTliNzktOGM4YjgxYjgwODY2IiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9.

Table 7: D-SNP Plans' Service Reach by Region beyond Washoe and Clark Counties

D-SNP	Rural[60]
Aetna	Carson City, Churchill, Douglas, Lyon, Nye, Storey
Alignment	Carson City, Douglas, Nye, Storey
Allwell	Carson City, Churchill, Douglas, Lyon, Nye, Storey
Anthem	Nye
Hometown	Carson City
Humana	Carson City, Churchill, Douglas, Lyon, Mineral, Nye, Storey
Molina	None
Prominence	Carson City, Churchill, Douglas, Lyon, Storey
United	Nye



Nevada D-SNP Experience and Quality

Federally, there are three types of D-SNP integration models: Coordination-Only, HIDE, and FIDE. Coordination-Only (also known as Acute Event notification process) plans have coordination between Medicare and Medicaid but do not share financial risk with Medicaid for LTSS and behavioral health services. HIDE plans have a high level of integration that offer Coordination-Only services. HIDE plans must have a contract with the state Medicaid agency and include coverage of LTSS or behavioral health benefits or both. FIDE plans fully integrate care for dually eligible beneficiaries under a single MCO. They must contract with the state Medicaid agency and include coverage of primary, acute, and LTSS benefits. FIDE plans must also cover behavioral health benefits, unless the state opts to carve them out of the capitation rate.[61] All of Nevada's current plans operate as Coordination-Only. Table 8 illustrates which of Nevada's plans have experience delivering more intensely integrated models (FIDE and HIDE) in other states.

[60] Nevada SMAC counties provided September 2023.

[61] "Medicare Advantage dual eligible special needs plans," available at https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/.

Table 8: D-SNP Plans' Experience in Other States with FIDE and HIDE Models[62]

D-SNP	FIDE (Fully Integrated)	HIDE (Highly Integrated)
Aetna	X	X
Alignment		X
Allwell	X	X
Anthem	X	X
Hometown		
Humana	X	X
Molina	X	X
Prominence		X
United	X	X

Every new SNP must have a MOC approved by NCQA. The MOC describes care management and care coordination practices used by the plan to meet the needs of people served. The MOC includes both clinical and non-clinical elements and is structured in four subsections: a description of the SNP population to be served, care coordination strategy, provider network composition and adequacy, and quality measurement and performance improvement approach.[63]

The evaluation of the MOC results in a score that results in a one- to three-year approval for the SNP to operate. The MOC score may be a good predictor for the quality of care that individuals will receive from a plan. Mercer reviewed the MOC scores and approval status of the plans. Table 9 below reflects subsection scores and the overall scores for each plan.

Table 9: D-SNP Plans' NCQA MOC Scores (reviewed July 2023)[64]

D-SNP	SNP Population	Care Coordination	Provider Network	Quality and Performance	Overall Score	Approval	Last Review
Aetna	100.00%	100.00%	100.00%	78.00%	92.67%	3 years	2021
Alignment	75.00%	100.00%	100.00%	100.00%	96.67%	3 years	2022
Allwell	100.00%	100.00%	93.33%	100.00%	98.75%	3 years	2023
Anthem	100.00%	100.00%	93.33%	100.00%	98.67%	3 years	2022
Hometown	90.00%	100.00%	100.00%	100.00%	98.67%	3 years	2022
Humana	100.00%	100.00%	100.00%	100.00%	100.00%	3 years	2021
Molina	100.00%	100.00%	100.00%	100.00%	100.00%	3 years	2023
Prominence	100.00%	100.00%	93.33%	100.00%	98.67%	3 years	2022

[62] "Special Needs Plan (SNP) Data," available at https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/special-needs-plan-snp-data.

[63] "Model of Care (MOC)," available at https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/model-care.

[64] "Model of Care Scores," available at https://snpmoc.ncqa.org/snp/list.

D-SNP	SNP Population	Care Coordination	Provider Network	Quality and Performance	Overall Score	Approval	Last Review
United	100.00%	92.00%	93.33%	100.00%	96.00%	3 years	2021

Overall, every D-SNP under contract in Nevada received a high score on the MOC review, with each plan receiving a three-year approval rating. The lowest section scores were 75% for Alignment's description of the population served and 78% for Aetna's description of quality measurement and performance improvement. Subsections of the MOC are weighted, and the overall score reflects the adjusted value for each section.

In addition to the NCQA MOC scores, Mercer reviewed the Medicare Advantage Star Ratings (Part C only) for the Nevada contracted plans. The Star Rating system helps Medicare consumers compare the quality of plans to help them decide in which to enroll.[65] The Star Rating scores are derived from an evaluation of five main functional areas: (1) staying healthy: screenings, tests, and vaccines; (2) managing chronic (long-term) conditions; (3) member experience with the health plan; (4) member complaints and changes in health plan's performance; and (5) customer service.[66] Table 10 shows Star Ratings for each plan from 2022 to 2023.

Table 10: CMS Medicare Advantage Star Ratings for D-SNP Plans 2022 and 2023 (Part C Only)[67]

D-SNP	Overall Score 2022 (1 Low–5 High)	Overall Score 2023 (1 Low–5 High)	Change
Aetna	3.5	3.0	↓
Alignment	N/A*	3.5	
Allwell	N/A*	2.0	
Anthem	3.5	2.5	↓
Hometown	4.5	4.5	=
Humana	4.5	4.5	=
Molina	N/A*	N/A*	
Prominence	3.5	3.5	=
United	N/A*	3.0	

*Plan too new to be measured or no listing for the plan with CMS.

Part C Star Rating scores for the Nevada plans ranged from a low of 2.0 to a high of 4.5. Hometown and Humana had the most consistent, and the highest overall Star Rating (4.5) among the plans measured. Aetna and Anthem each had a decrease in their overall score from 2022 to 2023.

[65] "Fact Sheet – 2022 Part C and D Star Ratings," available at https://www.cms.gov/files/document/2022-star-ratings-fact-sheet1082021.pdf.

[66] "2023 Medicare Advantage and Part D Star Ratings," available at https://www.cms.gov/newsroom/fact-sheets/2023-medicare-advantage-and-part-d-star-ratings.

[67] "Part C and D Performance Data," available at https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data.

Nevada D-SNP Supplemental Benefits

Supplemental benefits are additional benefits that plans offer that are not covered under traditional Medicare. In the increasingly competitive Medicare Advantage marketplace, supplemental benefits may differentiate one plan from its competitors. A review of the supplemental benefits for the Nevada plans was conducted by accessing the benefits booklets and pamphlets published by each plan. It is worth noting that while conducting this research, some plans' websites were much easier to access than others, and the summary of supplement benefits varied depending on enrollment in a health maintenance organization or preferred provider organization. Table 11 depicts the supplemental benefits for each plan offered during 2023.

Table 11: 2023 Supplemental Benefits for D-SNP plans

D-SNP	OTC Rx Coverage	Fitness Benefits	Pre-Paid Debit Card for Groceries/ Utilities/ Etc.	Addt'l Rx Discounts and Assistive Devices	Care Advocates Guides	Air Purifier	Service Animal Allowance
Aetna[68]	x	x		x	x		
Alignment[69]	x	x	x	x		x	
Allwell[70]	x		x				
Anthem[71]	x	x	x	x			
Hometown[72]	x	x		x			
Humana[73]	x	x	x		x		
Molina[74]	x	x	x	x			x
Prominence[75]	x	x	x		x		
United[76]	x	x	x				

The table below combines all three of the research metrics and illustrates a summarized comparison across all the D-SNP plans in Nevada, including Prominence prospectively.

[68] "Medicare Advantage plans with the benefits you may need," available at https://www.aetnamedicare.com/en/compare-plans-enroll/benefits-medicare-advantage-plan.html.

[69] "2023 Benefit Platter," available at https://www.alignmenthealthplan.com/media/AlignmentHealthPlan/PDFs/2023%20NV%20BH_004_005_001_%20final%20v2%20508.pdf.

[70] "$0 Prescriptions and Healthy Foods Benefit," available at https://wellcare.silversummithealthplan.com/vbid.html.

[71] "Summary of Benefits," available at https://file.anthem.com/MED2023/Y0114_23_3002534_U_M_0332.pdf.

[72] "2023 Medicare Enrollment Guide," available at https://brokers.hometownhealth.com/wp-content/uploads/2022/10/10615HTH_1902857_SCP_2023_BrokerSales_N.NV_text_MECH3_Web-Final.pdf.

[73] "Medicare Advantage Dual-Eligible Special Needs Plans," available at https://www.humana.com/medicare/medicare-advantage-plans/humana-special-needs/d-snp.

[74] "2023 Summary of Benefits," available at https://www.molinahealthcare.com/members/nv/en-us/-/media/Molina/PublicWebsite/PDF/members/common/en-us/Medicare/2023%20Documents/Summary%20of%20Benefits/NV001-2023-SNP-SB-EN-508.pdf.

[75] "Eligible for Both Medicare and Medicaid? Or Have Medicare's Extra Help? Discover our Special Benefits Plans," available at https://prominencemedicare.com/find-a-plan/know-your-medicare-options/special-benefit/.

[76] "2023 UnitedHealthcare Dual Complete® (HMO-POS D-SNP)," available at https://www.uhc.com/communityplan/nevada/plans/medicare/2023/dual-complete-hmo-pos-snp.

Table 12: Comparison of All Researched Metrics Across All D-SNP Plans

D-SNP	Enrollment August 2023*	Serves multiple rural counties in addition to Washoe and Clark**	FIDE/HIDE Experience†	Overall MOC Score#	Overall Medicare Advantage Star Rating 2023 Part C Only+	Number of Identified Supplemental Benefits Offered^
Humana						
Prominence	N/A					
Aetna						
Alignment						
Molina					N/A	
Anthem						
Hometown						
United						
Allwell						

* (Yellow = increase since January 2023 Blue = decrease since January 2023.)

** (Yellow = service in urban and multiple rural counties; Blue = service in Washoe, Clark, and/or only one rural county.)

† (Yellow = HIDE and/or FIDE; Blue = no FIDE or HIDE.)

(Yellow = 97%–100%; Blue = 92%–96%.)

+ (Yellow = rating is ≥ 3.0; Blue = rating is ≤ 2.9.)

^ (Yellow = between 4–5 supplemental benefits offered; blue = ≤3 supplemental benefits offered.)

N/A = data was not available (Enrollment for Prominence was not available because contract does not begin in Nevada until January 2024. Star Ratings were not available for Molina because initial CMS review and certification of this Molina plan was just completed in 2023.)

Reviewing all the metrics for the current and prospective D-SNP plans, Nevada has a diverse network of options for its eligible citizens. Humana noted positive metrics in all areas evaluated, showing growth, service beyond just the urban counties, experience with integrated models in other states, high scores on the MOC, the highest possible Medicare Advantage Star Rating in 2023, and a robust supplemental benefit package. Interestingly, United, as the fastest growing plan in terms of enrollment, is only currently serving one rural county beyond its urban counties and scored below its peers in both MOC score and supplemental benefits offered. Aetna, the third fastest growing plan, is serving more than just Clark and Washoe counties but also had the lowest MOC score, although it offered one of the richest supplemental benefit packages. Allwell scored lowest in growth, Star Ratings, and supplemental benefit offerings. It is clear from this research effort that the same plan can have quite a range of variability in overall positive scores and impressions depending on the focus of the evaluation. United had the greatest enrollment growth at 27%, with service only to Clark, Washoe, and Nye counties. The population of persons over age 55 years in Nevada has grown 32% from 2011 to 2019 and is expected to continue to grow until 2030.[77] It is hard to tell whether the increase in United's enrollment is being influenced by the quality of its

[77] "Elders Count Nevada 2023," available at https://adsd.nv.gov/uploadedFiles/adsdnvgov/content/About/Reports2/Elders_Count_2023-Final.pdf.

work and competitive position in the marketplace or simply reflects growth due to overall growth in the state's population, which occurs predominantly in the urban counties.

Much of how Nevada interprets this research depends on how the state wants to proceed with managing size and overall quality of its D-SNP network. If the goal, over time, is to progressively move toward more integrated models, it is likely that the plans with demonstrated FIDE and HIDE experience would be more likely to bring such experience to Nevada. If this is the approach that Nevada chooses to take, a more in-depth review of the same metrics of FIDE and/or HIDE plans in different states should be evaluated. If stability and predictability is important, Hometown, Humana, and Prominence had consistent Star Rating scores from 2022 to 2023; whereas Anthem and Aetna dropped in overall Star Rating performance from 2022 to 2023. Interestingly, while Aetna's Star Rating dropped in 2023, its enrollment grew by 14%. Anthem's Star Rating also dropped in 2023, with its enrollment also dropping by 13%.

Considerations

The current D-SNP plans in Nevada show a diverse range of size, experience, and quality from the metrics reviewed in this study. The national research in Section 3 of this paper offers additional insights as to how other states are shaping their respective D-SNP plans. Some of the strategies used to evolve D-SNP plan offerings include (1) the use of SMAC strategies, specifically those for managed care states, (2) thorough analysis of provider network composition and capacity, (3) close examination of care coordination models, and (4) specific quality and performance plans and reporting practices.

In addition to the aforementioned metrics, Mercer reviewed copies of 2023 Medicare Advantage Plan DSNP Enrollee Advisory Committee minutes provided by DHCFP to consider the degree that plans are seeking feedback from members as well as plan's overall adherence to the new CMS requirement for such committees.[78] Effective January 1, 2023, CMS instituted a new requirement that directs any Medicare Advantage plan offering one or more D-SNPs in a state must establish and maintain one or more enrollee advisory committees. The committees must include a reasonable representation sample of the population enrolled and solicit input on, among other topics, ways to improve access to covered services, coordination of services, and health equity for underserved populations. Because this is a new requirement, Mercer did not consider this to be content of primary consideration but offers some details of the review in Appendix C.

Mercer also attended a public hearing in Nevada, with DHCFP, health plans, and interested public parties, on August 23, 2023, to present Nevada's history to date with D-SNPs and the future goals, timelines, and Mercer's role. The hearing also was a forum to hear and receive feedback from parties attending live or virtually to be considered and utilized in DHCFP's decision process.

[78] "Code Of Federal Regulations § 422.107. Evidence requirements," available at https://www.ssa.gov/OP_Home/cfr20/422/422-0107.htm.

Section 7
Conclusion and Considerations

Conclusion

Nevada has many options and considerations now and for the future, with a longer trajectory toward eventual statewide managed care. Overall primary goals and optional pathways to achievement include the following summary:

The primary goals of any coordinated Medicare and Medicaid plans include:

- High-quality member care
- Member quality outcomes
- Managed costs
- High level of member satisfaction

These primary goals are best achieved from the best possible coordination between a well-integrated Medicare plan and Medicaid plan that coordinate the following:

- Benefits
- Appeals and grievances
- Claims
- Care coordination
- Care management
- Provider network
- Member education

These primary goals for benefits and services may be best achieved when there are the least obstacles and challenges to coordination between plans. One example of such coordination to consider is from affiliated MMPs under one parent company, where integration and coordination are intrinsic via one system, one department, one coordinator, one operation and its' policies versus two separate companies with separate operations that may find challenges and barriers from independent networks, benefits, coordination, care management, appeals platforms, policies, and goals.

Achieving such member quality goals may cause some initial disruption for some members to move to a new plan, but this will offer a pathway to achieving long-term, focused quality outcomes with the members' best interests supported through transitional continuity of care via network changes and the best possible coordination as needed per member.

Considerations

The considerations below include opportunities for DHCFP to consider when making decisions regarding D-SNP programs. These include opportunities to support future program and policy planning, assessment of the feasibility of direct capitation of behavioral health and/or LTSS, and the creation of a managed LTSS program.

- SMAC strategies:
  - Enhance care coordination services
  - Limit D-SNP enrollment to full-benefit, dually eligible beneficiaries
  - Partner with D-SNPs to develop supplemental benefit packages that compliment Medicaid benefits
  - Incorporate Medicaid quality improvement priorities into SMAC
  - Automatically assign D-SNP enrollees to Medicaid plans under the same parent organization
- LTSS
- Networks
- Care coordination
- Information sharing
- Supplemental benefits

Considerations for SMAC Strategies

DHCFP may consider the following SMAC strategies when determining modifications or updates to the SMAC:

- Require D-SNPs to use specific or enhanced care coordination methods.
- Automatically assign D-SNP enrollees to Medicaid plans under the same parent organization.
- Partner with D-SNPs to develop supplemental benefit packages that compliment Medicaid benefits.
- Incorporate Medicaid quality improvement priorities into the SMAC.
- Limit D-SNP enrollment to full-benefit, dually eligible beneficiaries.

The above strategies support further integration between Medicaid and Medicare benefits.

Long-Term Support and Services

LTSS encompasses a broad range of services designed to meet chronic illness, disability, or aging-related needs, and services that are often the same critical services for D-SNP populations.

Some states are transitioning their LTSS population into a managed care delivery system to provide a comprehensive benefits package that includes physical and behavioral health services and LTSS under a single capitated rate. This, in some states, has involved expanding their existing managed care program to include this population, while other states have contracted with a specialized managed care plan to focus solely on this population.

A strategy to consider is a population phased-in approach, in which the state could initially exclude certain subpopulations, such as individuals receiving LTSS in a nursing facility or other institutional setting and include them later after the state and health plans build capacity to serve the LTSS population, which is another consideration to include LTSS in the D-SNP plan or include via a separate specialty plan. This strategy, if considered by Nevada, would require confirmation that HCBS providers are able to contract with health plans and receive timely payments. The state could consider making them an essential community provider for contracts with plans.

Benefits from joining LTSS and D-SNP benefits are summarized below.

Considerations to join LTSS and D-SNP would be based on the ability to offer more integrated and comprehensive care to dual-eligible members. Joining LTSS and D-SNPs under Medicaid benefits dual eligibility individuals by offering more integrated care, simplifying processes, and enhancing the overall quality of care. This is a step toward a more unified healthcare system for individuals who require both Medicare and Medicaid services, as noted below.

- **Integration of Medicaid LTSS and Behavioral Health Services:** Highly integrated D-SNPs provide Medicaid LTSS and behavioral health services. This integration is crucial for ensuring that members receive a comprehensive range of services, including community-based LTSS services, which are essential for promoting independence and allowing members to remain in or return to community settings. Proper oversight and plan infrastructure are necessary to provide these services effectively.[79, 80]
- **Streamlines Processes and Member Services:** Integration leads to a more streamlined enrollment, notice, and member services process. This includes a single enrollment mechanism, a single identification card, and integrated notices and member materials. Such a system reduces confusion and promotes a seamless experience for enrollees. However, it is important to balance integrated enrollments with maintaining member choice and avoiding disruptions in care.[81, 82]

[79] "Medicaid-Capitated D-SNPs: An Innovative Path to Medicare-Medicaid Integration," available at https://atiadvisory.com/resources/medicaid-capitated-d-snps-an-innovative-path-to-medicare-medicaid-integration/.

[80] "Integrating Care through Dual Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges," available at https://aspe.hhs.gov/reports/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-challenges-0.

[81] "State Efforts to Integrate Care Across Medicaid FFS LTSS and Medicare Advantage D-SNPs," available at https://www.healthmanagement.com/blog/state-efforts-to-integrate-care-across-medicaid-ffs-ltss-and-medicare-advantage-d-snps/.

[82] "Dual Eligible Special Needs Plans: Considerations for Reauthorization – Center for Medicare Advocacy," available at https://urldefense.com/v3/__https://medicareadvocacy.org/dual-eligible-special-needs-plans-considerations-for-reauthorization/__;!!O7V3aRRsHkZJLA!G6TkHnNyUbGKy8iJ4IOfeWLvflbAJpfz9cMJUrZyj1pOtHeqxX-mEJ8PU_wRrHRT-b6p4CkUl_RGSwF7QI0$.

- **Integrated Appeals and Grievances:** An integrated D-SNP appeals process combines Medicare and Medicaid appeals, alleviating confusion and administrative burden. This process must retain crucial consumer protections with clear healthcare appeal decision pathways for each program.[83, 84, 85, 86]
- **Medicaid-Capitated D-SNPs:** A combined model of Medicaid and Medicare under a single contract with a pathway to MLTSS in a state without an MLTSS infrastructure. The goal is to improve member experience through unified care models and management teams, and targeted benefit designs while reducing redundancy and misaligned financial incentives.[87, 88]
- **Contracting with States:** D-SNPs have contracts with states, as required by the Medicare Improvements for Patients and Providers Act of 2008 and the Affordable Care Act, to provide Medicaid benefits or arrange for them and serve and coordinate care for dual-eligible members. States have considerable flexibility in how they use these contracts to promote higher levels of Medicare-Medicaid integration.[89, 90]

Additionally, consideration for waivers for LTSS may also be an option, and there is a lesson learned from the state of Virginia regarding waiver strategy. Virginia originally intended to implement its integrated MLTSS program, Commonwealth Coordinated Care Plus, through an 1115 waiver. However, it realized after several months of planning and negotiations that Virginia's existing Medicaid program cost trends made the 1115 cost neutrality requirements challenging, particularly if unanticipated future costs were to increase for the LTSS population. Therefore, Virginia changed course and worked closely with CMS to migrate to a 1915(b)(c) choice waiver, which provided the flexibilities needed for its program.

It is important to note the following information on 1915 waivers:

The 1915(b) and 1915(c) waivers in Medicaid offer states the flexibility to manage their Medicaid services more effectively and cater to specific populations or service needs. Virginia's use of these waivers, particularly in comparison to a Section 1115 waiver, reflects strategic choices to tailor Medicaid services to the needs of its residents.

- **1915(b) "Freedom of Choice" Waivers:** These waivers allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid. In Virginia, a 1915(b) waiver could be used to streamline the delivery of Medicaid services, focusing on efficiency and cost-effectiveness, often through the establishment of MCOs. These waivers are effective for states looking to control costs

[83] "D-SNPs: Integration & Unified Appeals & Grievance Requirements," available at https://www.cms.gov/medicaid-chip/medicare-coordination/qualified-beneficiary-program/d-snps-integration-unified-appeals-grievance-requirements.

[84] "Integrated Appeal and Grievance Processes for Integrated D-SNPs with 'Exclusively Aligned Enrollment'," available at https://www.integratedcareresourcecenter.com/resource/integrated-appeal-and-grievance-processes-integrated-d-snps-exclusively-aligned-enrollment.

[85] "CMS Releases Final Rule on D-SNP Integration and Integrated Appeals," available at https://www.integratedcareresourcecenter.com/e_alert/cms-releases-final-rule-d-snp-integration-and-integrated-appeals.

[86] "Dual Eligible Special Needs Plans: Considerations for Reauthorization - Center for Medicare Advocacy," available at https://urldefense.com/v3/__https://medicareadvocacy.org/dual-eligible-special-needs-plans-considerations-for-reauthorization/__;!!O7V3aRRsHkZJLA!BhqoOZPxqPkySOAhBcZSqJmTV2hJiuR96DWfJNqhhFtoEOgic1x31ZKnYsw25JooS28b8CD12WJDaAPQp04$.

[87] "Medicaid-Capitated D-SNPs: An Innovative Path to Medicare-Medicaid Integration," available at https://atiadvisory.com/resources/medicaid-capitated-d-snps-an-innovative-path-to-medicare-medicaid-integration/.

[88] "Integrating Care through Dual Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges," available at https://aspe.hhs.gov/reports/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-challenges-0.

[89] Ibid.

[90] "Dual Eligible Special Needs Plans (D-SNPs)," available at https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/dual-eligible.

and coordinate care more effectively without fundamentally changing the nature or eligibility criteria of their Medicaid programs.

- **1915(c) "Home and Community-Based Services" (HCBS Waivers:** These waivers permit states to provide long-term care services in home and community settings rather than institutional settings. A 1915(c) waiver for Virginia would be particularly effective in expanding access to community-based services for populations such as the elderly, individuals with disabilities, or those requiring long-term care. This helps in enhancing the quality of life for members by allowing them to receive care in more comfortable, less restrictive environments.
- **Comparison with Section 1115 Waivers:** Section 1115 waivers are broader and more flexible than 1915 waivers. They allow states to test new or existing ways to deliver and pay for health care services in Medicaid and Children's Health Insurance Program (CHIP. A 1115 waiver might be more comprehensive, impacting a broader segment of the Medicaid population and potentially introducing more fundamental changes to the program such as expanding eligibility, testing new service delivery models, or implementing work requirements.

For Virginia, opting for a 1915(b) or 1915(c) waiver over a 1115 waiver could mean focusing more on specific service delivery reform (e.g., managed care models or expanding community-based services) rather than broader programmatic changes. These waivers could be more targeted in their approach, addressing specific care delivery or setting-related goals, which can be more straightforward to implement and manage.[91, 92, 93]

Ultimately, any effort to shape the D-SNP program in Nevada should consider the quality of care, total benefits package, accessibility of services, and customer experience for each plan. Having diversity among the plans can offer both a competitive market and one which should be reflective of the needs of aging Nevadans. Finally, it is recommended that further research consider examination of health equity initiatives underway by current health plans to assess the health plans' success and interest in improving disparities in health care experienced by vulnerable, priority populations.

Considerations for Enrollment

Nevada could consider SMAC strategies to support aligned enrollment, which could benefit both beneficiaries and plans. An example is for Nevada to automatically assign D-SNP enrollees to Medicaid plans under the same parent organization.

Considerations for Networks

Nevada's shortage of specialists is a current and long-term matter that requires long-term considerations on various levels, including state and other funding for resident positions, provider burnout programs, including provider mental health promotion, team-based provider care (e.g., telemedicine teams), efficiency via technical platform utilization (e.g., telemedicine). Nevada could consider telemedicine for efficiency reasons to provide care to more members without direct provider/patient care setting, when necessary, to address state provider shortages. Regarding provider-to-member ratios, Nevada catchment

[91] "State Waivers List," available at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.

[92] "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State," available at https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

[93] "Virginia Medicaid," available at https://www.dmas.virginia.gov/.

areas may need a unique applicable standard as well. Geographic considerations would also be a consideration for Nevada's catchment areas, especially when a member may have a network to a bordering state due to network provider availability/shortages. Consideration for evaluating and examining current state standards annually should have a state review and requirement of health plans to submit to state review.

Considerations for Care Coordination

The state could consider aligning the MOC and SMAC timelines to support enhanced coordination. The risk assessment of membership is key to understanding the member's needs and being able to coordinate and manage care. Consider the following options for this key component of the member risk assessment:

- Require D-SNPs to integrate Medicaid assessment tools or questions with D-SNP health risk assessment (HRA).
- Require D-SNPs to include Medicaid managed care plan or community agency representatives in the assessment process.
- Require HRAs to be conducted within specific timeframes.
- Require use of specific modalities, such as in-person meetings, for certain enrollees.

A state consideration for transition of care services may focus on state requirements for D-SNP care coordination, to collaborate with other entities, (e.g., Medicaid care management staff, Medicaid MCOs, State Department on Aging, waiver coordinators).

Again, the use of single parent MMPs may ensure a more intrinsic and seamless care coordination between D-SNP and Medicaid programs, with better member outcomes.

Considerations for Information Sharing

DHCFP could consider requiring an enhanced system of information sharing to foster collaboration between the state and the D-SNPs. The state could consider a system similar to Tennessee's system, which requires D-SNPs to submit data on admissions every two business days. Tennessee also requires quarterly care coordination reports for state review. DHCFP could consider pursuing this as a strategy for quality oversight and information-sharing enhancements. For further information on Tennessee's information sharing requirements, see Appendix A of this report. The state could also consider an approach used in Oregon, in which an event notification system (ENS) is used by D-SNPs, Medicaid plans, and providers, to strengthen information sharing with respect to managing care for this population, further detailed in Appendix A of this report.

Considerations for Supplemental Benefits

Considerations for states regarding supplemental benefits include efforts to avoid duplication, limitation on offerings, variation in rebate dollars, and potential value to the plan.[94] Further considerations include requiring data sharing between Medicaid, Medicare, and the state, to foster collaboration, and adding language to the SMAC requiring D-SNPs to collaborate with the state in developing supplemental benefits.[95] This could look similar to the program in Minnesota, in which D-SNPs and the state meet annually to discuss how supplemental benefits fit into the plan's larger benefit package.[96]

Care coordination services are defined as the management and integration of diverse healthcare services that dual-eligible individuals require and prefer to improve health outcomes from comprehensive, person-centered care and the coordination of all services between Medicare and Medicaid health plans for each member as applicable.[97, 98]

Some state examples for improving coordination of benefits include having one parent company for MMPs. States can take further action by requiring plans to get state approval of member materials and requiring strong care coordination services. Care coordination can be focused on strategies that serve the member of the selected benefits with coordination between Medicare and Medicaid plans, and coordination specifically of education services and navigational services for the best outcomes and member experience.

Additional study may be warranted to better understand the role and importance of supplemental benefits in evaluating the overall merit and quality of a D-SNP. Although it gives one impression of a plan to see that benefits are offered, it may be an entirely different impression to see actual utilization of supplemental benefits and the degree of customer satisfaction specific to those benefits. Similarly, looking at care coordination performance from the national core indicators and surveys may offer additional perspective to the Star Ratings scores for the Medicare Advantage plans.

Nevada may consider partnering with future plans to ensure that benefit packages for Medicare to Medicaid are not duplicative and confusing to members and that they align, where possible. This type of alignment between benefit packages is especially important when the Medicare and Medicaid plans are not affiliated with the same parent company.

Ensuring plans share details about care coordination programs may be the strongest consideration to ensuring quality outcomes for members. This is especially helpful when the care coordination program complements any benefit package design, making it a richer and more positive experience for the member. Nevada's current benefits and services could be improved with a robust care coordination model that meets the Nevada population's needs and aids with member access, utilization, and outcome satisfaction. If the population's needs are met through other avenues, such as PACE, then the benefit package may have a different focus.

[94] Integrated Care Resource Center. "Working with Medicare Medicare 201: Actions States Can Take to Improve Quality and Coordination of Care for Dually Eligible Individuals," available at https://www.integratedcareresourcecenter.com/sites/default/files/WWM%20201%20Slide%20Deck_%20for%20508.pdf.

[95] Ibid.

[96] Ibid.

[97] "Care Coordination," available at https://www.cms.gov/priorities/innovation/key-concepts/care-coordination.

[98] "Special Needs Plans (SNP)," available at https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/SNP.

Summary of Considerations

DHCFP can consider the following summarized approaches to strengthen its D-SNP program:

- Adopt strategies to strengthen the SMAC and support the integration of Medicaid and Medicare benefits and services:
  - SMAC requirements for enrollment, quality, networks, coordination, and state reporting.
- Phase-in the LTSS population into a managed care structure that aligns with the D-SNP program.
- Consider use of telehealth to support network adequacy, especially in rural regions.
- Utilize HRA measures to support care coordination.
- Use a state-driven information sharing approach.
- Consider further development of a PACE program(s).
- Establish options for possible roles and outcomes of affiliated MMPs.

Section 8
Glossary

Table 13

Term	Definition
Default enrollment:	Enrollment process that allows a Medicare Advantage organization, following approval by the state and CMS, to enroll — unless the member chooses otherwise — a member of an affiliated Medicaid MCO into its Medicare D-SNP.[99]
Exclusively aligned enrollment:	Medicaid MCO that furnishes Medicaid benefits the same as the D-SNP, the D-SNP's parent organization, or is owned and controlled by the D-SNP's parent organization.[100]
Financial alignment initiative (FAI):	A state and federal option to enroll dual-eligible beneficiaries into integrated Medicaid and Medicaid programs that cover primary, acute, behavioral health, and LTSS.[101]
Fully integrated dual eligible-SNP (FIDE):	FIDE SNPs fully integrate care for dually eligible beneficiaries under a single MCO. FIDE SNPs must include coverage of primary, acute, and LTSS benefits. FIDE SNPs must also cover behavioral health benefits, unless the state carves behavioral health out of the capitation rate.[102]
Highly integrated dual eligible-SNP (HIDE):	Higher level of integration than typical D-SNP. Must have a contract with the state Medicaid agency that includes coverage of LTSS and/or behavioral health.[103]
Model of care (MOC):	Every new SNP must have a MOC approved by the NCQA. The MOC is considered a vital quality improvement tool and describes care management and care coordination practices used by the plan to meet the needs of people served.[104] The MOC standards below are scored and evaluated:[105]

[99] "Default Enrollment FAQs," available at https://www.integratedcareresourcecenter.com/sites/default/files/HPMS%20Level%201%20Memo%20-%20Default_Enrollment_FAQs_2-25-19.pdf.

[100] "Guidance for States Seeking to Leverage New Opportunities for Integrated Care Programs," available at https://www.cms.gov/files/document/stateoppsintegratedcareprogs.pdf.

[101] Integrated Care Resource Center. "Working with Medicare Medicare 201: Actions States Can Take to Improve Quality and Coordination of Care for Dually Eligible Individuals," available at https://www.integratedcareresourcecenter.com/sites/default/files/WWM%20201%20Slide%20Deck_%20for%20508.pdf.

[102] MACPAC. "Medicare Advantage dual eligible special needs plans," available at https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/.

[103] Ibid.

[104] "Model of Care (MOC)," available at https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/model-care.

[105] "Scoring Guidelines CY 2025 Scoring Guidelines," available at https://snpmoc.ncqa.org/scoring-guidelines-latest.

Term	Definition
	• **SNP population:** The organization's MOC description of its target population must (1) describe how the health plan staff will determine, verify, and track eligibility of SNP enrollees; (2) describe the medical, social, cognitive, and environmental factors, living conditions, and comorbidities associated with the SNP population; (3) identify and describe the medical and health conditions impacting SNP enrollees; and (4) define the unique characteristics of the SNP population served. • **Care coordination:** Regulations at 42 CFR § 422.101(f)(2)(ii-v); 42 CFR § 422.152(g)(2)(vii-x) require all SNPs to coordinate the delivery of care and measure the effectiveness of the MOC delivery of care coordination. Care coordination helps ensure that the health care needs, preferences for health services, and information sharing across health care staff and facilities are met over time for each SNP enrollee. Care coordination maximizes the use of effective, efficient, safe, high-quality patient services (including services furnished outside the SNP's provider network) that ultimately lead to improved health care outcomes. The MOC 2 elements presented in this section are essential components to consider in the development of a comprehensive care coordination program; no element must be interpreted as being of greater importance than any other. Taken together, all six elements must comprehensively address the SNP's care coordination activities: (1) SNP staffing structure, (2) HRA tool, (3) face-to-face encounter, (4) individualized care plan, (5) interdisciplinary care team, and (6) care transition protocols. • **Provider network:** The SNP provider network is a network of health care providers contracted to provide health care services to SNP enrollees. The SNP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized health care needs of the target population as identified in MOC 1 and provide oversight information for all its network types. SNPs must ensure that their MOC identifies, fully describes, and implements the following elements for their SNP provider networks: (1) specialized expertise, (2) use of clinical practice guidelines and care transition protocols, and (3) MOC training for the provider network. • **Quality measurement and performance improvement:** Regulations at 42 CFR § 422.152(g) require that all SNPs conduct a quality improvement program that measures the effectiveness of its MOC. The goal of performance improvement and quality measurement is to improve the SNP's ability to deliver health care services and benefits to its SNP enrollees in a high-quality manner. Achievement of this goal may be the result of increased organizational effectiveness and efficiency through incorporation of quality measurement and performance improvement concepts that drive organizational change. The leadership, managers, and governing body of a SNP organization must have a comprehensive quality improvement program in place to measure its current level

Term	Definition
	of performance and determine whether organizational systems and processes must be modified based on performance results.
Partially integrated D-SNP:	Individuals only receive Medicare Savings Program benefits without full Medicaid benefits.[106]
Program of All-Inclusive Care for the Elderly (PACE):	Provides comprehensive medical and social services to certain frail, community-dwelling, elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. An interdisciplinary team provides participants with coordinated care.[107]

[106] Integrated Care Resource Center. "Working with Medicare State Contracting with D-SNPs: Using D-SNPs to Integrate Care for Dually Eligible Individuals," available at https://www.integratedcareresourcecenter.com/sites/default/files/WWM%20D-SNP%20201_FINAL.pdf.

[107] "Program of All-Inclusive Care for the Elderly," available at https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html#:~:text=The%20Programs%20of%20All-Inclusive,for%20Medicare%20and%20Medicaid%20benefits.

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Appendix A
Information Sharing

Further details regarding state approaches to information sharing are below:

- Oregon, a managed care and FFS state, leverages an ENS. Oregon SMACs require plans to share key information about enrollees to all relevant providers. Oregon's ENS EDIE documents information on statewide hospital admissions, discharges, and transfers.[108] EDIE alerts emergency department (ED) physicians in real-time when a patient, who is a frequent user of hospital and ED services, registers in their ED. Alerts can include previous ED and inpatient data from any hospital in Oregon, Washington, and parts of California and Idaho. Hospitals can also use it as a search tool, where there is also a care team section in which users can view all providers for the individual. EDIE has a companion web portal, Collective Platform, that alerts subscribers to admission events in real-time.[109] It expands access to the EDIE hospital, ED, and SNF event notification and other key data elements to D-SNPs, coordinated care organizations, providers, and LTSS care management agencies.[110]
- Tennessee, a MLTSS state, uses a state-driven, information-sharing approach. Tennessee requires daily and quarterly care coordination reports, which include hospital and SNF admission data, a care coordinating request form, and a data portal that plans can use to submit and access information.[111] The state requires D-SNPs to submit data on admissions every two business days via the Inpatient Census Report, to facilitate timely information exchange and discharge planning. This report is submitted by all D-SNPs every day to appropriate Medicaid plans via state-administered file transfer protocol site.[112] Tennessee also requires D-SNPs to submit quarterly dual care coordination reports for the state to review and use during discussions with D-SNPs as a method for tracking and trending coordination efforts.[113]
- In Pennsylvania, an MLTSS state, all MLTSS plans operate a SNP, although there are also D-SNPs that do not participate in MLTSS. Pennsylvania uses a plan-driven, information-sharing approach to share information on a broad group of enrollees.[114] The state prompted plans to work together to develop an information-sharing approach. D-SNPs and MLTSS plans share relevant admission information on hospital and SNF stays with Medicaid case management and behavioral health organizations that deliver behavioral health services to D-SNP enrollees.[115] SMAC requires that MCOs and D-SNPs work together to reconcile information, such as medication records and care plans, as a part of a broader MLTSS care transition strategy.[116]

[108] Integrated Care Resource Center. "Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations," available at https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_InfoSharing_HospitalSNF%20082819.pdf.

[109] Ibid.

[110] Ibid.

[111] Ibid.

[112] Ibid.

[113] Ibid.

[114] Ibid.

[115] Ibid.

[116] Ibid.

Appendix B
PACE

PACE: Information as noted from Medicare website PACE | Medicare.

PACE is a Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility.

If you join PACE, a team of health care professionals will work with you to help coordinate your care.

How does PACE work?

PACE covers all Medicare- and Medicaid-covered care and services, and anything else the health care professionals in your PACE team decide you need to improve and maintain your health. This includes prescription drugs and any medically necessary care.

Here are some of the services PACE may cover:

- Adult day primary care (including doctor and recreational therapy nursing services)
- Dentistry
- Emergency services
- Home care
- Hospital care
- Laboratory/x-ray services
- Meals
- Nursing home care
- Nutritional counseling
- Occupational therapy
- Physical therapy
- Preventive care
- Social work counseling
- Transportation to the PACE center for activities or medical appointments

You will get your Part D covered drugs and all other necessary medication from the PACE program. If you join a separate Medicare drug plan while you are in the PACE program, you will be disenrolled from PACE.

Who can get PACE?

The PACE program is only available in some states that offer PACE under Medicaid.

You can join PACE, even if you do not have Medicare or Medicaid, if you:

- Are at least 55 years old
- Live in the service area of a PACE organization
- Need a nursing home-level of care (as certified by your state)
- Are able to live safely in the community, with help from PACE

What does PACE cost?

If you have Medicaid, you will not pay a monthly premium for the long-term care portion of the PACE benefit.

If you do not qualify for Medicaid, but you have Medicare, you will pay:

- A monthly premium to cover the long-term care portion of the PACE benefit
- A premium for Medicare Part D drugs

There is no deductible or copayment for any drug, service, or care your health care team approves. If you do not have Medicare or Medicaid, you can pay for PACE yourself.

How do I apply for PACE?

To find out if you are eligible, and if there is a PACE program near you, search for PACE plans in your area or call your Medicaid office.

Appendix C
2023 Enrollee Advisory Committee Meeting Minutes

Starting in January 2023, Medicare Advantage plans operating one or more D-SNPs within a state are required to establish enrollee advisory committees to help with plan governance and to help improve performance. Mercer received copies of meeting minutes through DHCFP from six of the eight contracted plans. This section summarizes the materials available that were reviewed and includes recommendations for Nevada to consider when receiving and considering this content in the future.

The enrollee advisory committees, per 42 CFR § 442.107.f[117] should represent the member enrollment and solicit input on a variety of topics including, but not limited to, access to covered services, coordination of services, and health equity of underserved populations.

Plans minutes showed effort to explain the purpose of the advisory committees and primarily offered virtual and telephonic participation options, though some plans conducted in-person meetings as well, with the option to call in. Some plans offered a standard meeting format, based upon the recommended topics outlined by CMS. Some minutes transparently showed attendance composition for each meeting, both reflecting the plan's staff who participated as well as the members who attended.

Minutes varied as to the content which they addressed, with some plans using an agenda of the same recurring topics, while others dedicated single meetings to a single or select few topics. Overall, these minutes reflected individual or collective member experiences regarding use of benefit cards, accessing services, customer service quality, and quality of engagement with the plan both in person and electronically via websites and applications.

Recurring themes across plans included member feedback that plan written materials and benefits were often challenging to access and to understand. There were mixed levels of understanding of how to access case manager support, although overall experiences with care managers were recorded as positive. Members stressed the importance to them of transportation, dental coverage, over-the-counter coverage, and many indicated praise for a plan's availability of supplemental benefits, including health allowance cards. Some minutes indicated that while members appreciated regular contact with their plan, many indicated that the intensity and frequency of contact was too much.

In the future, Nevada should consider who will review these minutes and how the input provided through the enrollee advisory committees is used to affect quality improvement initiatives. Understanding each plan's workflows of how these committees connect with other quality improvement and quality assurance efforts could be something for Nevada to consider when evaluating the overall quality of its D-SNP network.

[117] "Code of Federal Regulations § 422.107. Evidence requirements," available at https://www.ssa.gov/OP_Home/cfr20/422/422-0107.htm.

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