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**Office of Aging and Disability Services
&
Office of MaineCare Services**

**Recommendations for Reform:
Aging & Long-Term Services and Supports**

December 31, 2019

Acknowledgments

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 Maine Center for Disease Control
 Office of Aging & Disability Services
 Office for Family Independence
 Office of MaineCare Services
 Office of Substance Abuse & Mental Health Services
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Executive Summary

On May 7, 2019, the Maine Department of Health and Human Services (the Department) hosted a Convening on Aging and Long-Term Services and Supports (the “Convening”) to establish priorities for aging and Long-Term Services and Supports (LTSS) reform. Over 60 stakeholders attended from around the state, including the five Area Agencies on Aging (AAAs), advocates, providers, legislators and several State agencies. At that meeting, the Department received valuable feedback on its reform priorities and proposed the formation of the Aging and LTSS Advisory Committee, (the “Committee”) to develop specific recommendations for policy and program changes.

The Committee met four times from June to October of 2019. During these gatherings, the Committee considered information about Maine’s existing services, studied innovative models from other states, reviewed federal opportunities, and formulated recommendations. Also, during this process, the Department released a joint Request for Information (RFI) from the Office of Aging and Disability Services (OADS) and the Office of MaineCare Services (OMS) to assess interest in models that integrate Medicare and Medicaid (MaineCare) services for Mainers who have both types of insurance coverage. The Committee’s recommendations include:

- ✓ Implement Community First Choice (CFC), a Medicaid Home-and Community-Based Services (HCBS) State Plan Option under Section 1915(k) of the Social Security Act, which provides a six-percentage point enhancement in federal matching funds;
- ✓ Expand the use of Assistive Technology (AT) and environmental modifications;
- ✓ Simplify entry into Maine’s LTSS system;
- ✓ Make care coordination more effective and efficient;
- ✓ Make LTSS policy consistent across MaineCare and State-funded programs, to the greatest extent practical;
- ✓ Continue to study options to strengthen coordination for dually eligible individuals, including managed fee-for-service models that build on Maine’s Health Homes, and capitated managed care models with Medicare-Medicaid Plans (MMPs), D-SNPs, or other accountable entities;
- ✓ Strengthen data analysis and data sharing infrastructure; and,
- ✓ Update the Department’s contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) to strengthen coordination between Medicare and MaineCare and conform with new federal requirements that take effect in 2021.

Introduction

Maine’s population is growing older and living longer. Maine’s population is currently the oldest in the nation. Older adults (60 years of age and older) already comprise nearly a third of the state’s total population, reflecting the aging of Maine’s Baby Boomers (Figure 1). In the coming years, the percentage of older adults will increase as the number of working-age Mainers (ages 20-64) declines or remains flat (Figure 2). These shifts in population are already impacting Maine’s workforce and economy, as evidenced in the shortage of direct support and healthcare professionals across the state.

Figure 1: Maine Population Distribution, 2016

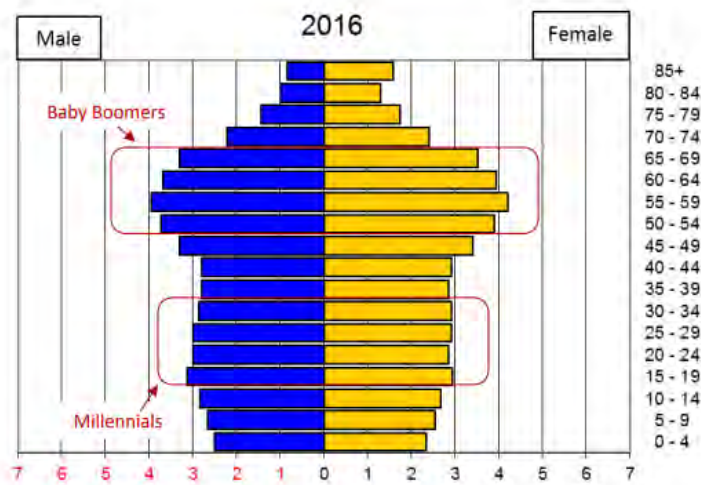


Figure 2: Maine Population Outlook, 2016-2026

Maine Statewide Population by Age				
	2016 (historical)	2021	2026	2016-2026
Age 0-19 years	287,581	265,943	253,938	
Age 20-39 years	308,280	315,515	314,612	
Age 40-64 years	476,872	446,545	420,032	
Age 65+ years	257,499	307,257	351,880	
Five-Year Percent Change				
Percent Change 0-19		-8%	-5%	-12%
Percent Change 20-39		2%	0%	2%
Percent Change 40-64		-6%	-6%	-12%
Percent Change 65+		19%	15%	37%

Source for Figures 1 and 2: Maine State Economist, December 2018:

<https://www.maine.gov/dafs/economist/sites/maine.gov.dafs.economist/files/inline-files/Maine%20Population%20Outlook%20to%202026.pdf>

One of the Department of Health and Human Services' responsibilities is to focus on, and plan for, the opportunities and challenges of Maine's aging population. The Office of Aging and Disability Services (OADS) develops and implements the State Plan on Aging, develops evidence-based policies and programs, and identifies, leverages, and coordinates resources to support services for older persons. A key vision of the Department is: *Older Mainers live with dignity in the place that balances their needs and preferences.* To this end, DHHS Commissioner Jeanne M. Lambrew charged OADS and partnering DHHS offices with convening a cross-section of aging and Long-Term Services and Supports (LTSS) stakeholders and preparing recommendations to expand access to in-home supports and improve coordination for dually eligible Medicare-MaineCare beneficiaries. This report contains those recommendations.

Aging and LTSS Convening

On Tuesday May 7, 2019, approximately 60 stakeholders from throughout the state, including consumers, the five AAAs, advocates, providers, legislators, and multiple State agencies attended the State Convening on Aging and Long-Term Services and Supports to help shape the future of aging and LTSS in Maine. The objectives of the Convening were to review opportunities and challenges related to aging in Maine; gather feedback on Governor Mills' administration's priorities for aging and LTSS; and establish a process to advance policy in this area.

The priorities of the Mills administration include: expand access to in-home supports and other strategies for living and aging in place; strengthen coordination of Medicare and Medicaid for those who have both (dually eligible beneficiaries); and expand and retain the direct services workforce. Following the Convening, DHHS Commissioner Jeanne M. Lambrew appointed the Aging and LTSS Advisory Committee to formulate specific policies to advance these priorities.

In addition, the Department held eight public listening sessions in October 2019 as part of its work to renew the State Plan on Aging in 2020. In order to receive federal Older Americans Act funds, states must renew their State Plans on Aging at least every four years. This work complemented the Advisory Committee's work and included many Advisory Committee members and other stakeholders.

Advisory Committee Activities

The Aging and LTSS Advisory Committee held four half-day meetings from June to October of 2019. During these meetings, members heard from stakeholders about current system challenges and opportunities for reform and reviewed other states' experiences with implementing innovative service models. The Committee focused its efforts on expanding access to in-home supports for older adults and adults with physical disabilities and improving care coordination

for beneficiaries who are dually eligible for Medicare and MaineCare. The Committee had also expected to look at ways to expand and retain the direct services workforce, but just prior to the first Committee meeting, the Legislature established the Commission to Study Long-term Care Workforce Issues to develop policy recommendations to recruit and retain direct support professionals. Rather than duplicate the work of the Commission, the Aging and LTSS Advisory Committee opted to support the Commission's work as appropriate and focus on its other two priority areas:

1. Expanding Access to In-Home Services and Related Strategies to Support Living and Aging in Place; and
2. Strengthening Coordination for Beneficiaries with Medicare and MaineCare (dually eligible individuals).

This report presents recommendations in these two areas.

Focus Area 1: Expanding Access to In-Home Services and Related Strategies to Support Living and Aging in Place

As Maine’s population ages, a key policy objective is to enable as many older Mainers as possible to age in place. Older adults have consistently expressed a strong preference for remaining in their homes or other community settings as their needs change, and supporting that preference is cost-effective relative to nursing facility care. Maine offers a variety of Home and Community Based Services (HCBS) through MaineCare, the Older Americans Act, and state-funded programs for older adults and adults with physical disabilities. Several of the HCBS programs have undergone incremental change, but they have not been updated comprehensively in several years, resulting in misalignment of policy across programs. New federal options have since become available, and the significant workforce shortage is stimulating new thinking about the use of technology and other innovations in service delivery. Research on social determinants of health has shown a strong link between HCBS and health, yet some of Maine’s HCBS case management policies may constrain the HCBS and healthcare sectors from coordinating their services. With these issues in mind, the Committee considered ways to address the following goals related to HCBS access:

1. Expand access to home- and community-based options;
2. Enhance the scope of LTSS care coordination; and
3. Revise current MaineCare and State-funded LTSS program policies to provide streamlined service delivery and maximize federal funding.

Recommendation: Create a Medicaid Community First Choice (CFC) Program under Section 1915(k) of the Social Security Act.

Maine currently operates an HCBS waiver program for older adults and adults with physical disabilities under Section 1915(c) of the Social Security Act. Since their initiation, HCBS waiver programs have become permanent offerings in every state, and relatively new federal Medicaid options now allow states to offer HCBS without waivers, as a Medicaid State Plan option. The Committee considered two State Plan options, under Sections 1915(i) and 1915(k), to see if they could help Maine advance living and aging in place. Figure 3 compares the main features of each. The options are similar in several ways, but two key features are different. Both require the state to establish functional level of care criteria, but the 1915(i) offers more flexibility in this area. The level of care under 1915(k) must be the same as the state’s institutional (nursing facility) level of care, but the level of care under 1915(i) may be different than the institutional level of care, which would enable an at-risk group to be defined and served. The options also differ in

that the 1915(k) offers a six-percentage point increase in the federal match rate, whereas the 1915(i) does not.

Figure 3: Features of State Plan HCBS Options

	1915(i)	1915(k)
Functional Level of Care	State may establish a level of care that differs from institutional level	State must use the institutional level of care
Enhanced Federal Match	None	6% enhanced federal match
Target Groups	May define sub-populations based on conditions	Targeting based on condition not allowed
Service Delivery Models	Both agency-delivered and consumer-directed models are included	Both agency-delivered and consumer-directed models are included
Key State Plan Requirements	<ul style="list-style-type: none"> • Freedom of choice • Comparability • Statewide • Program may not be capped at a set number of participants 	<ul style="list-style-type: none"> • Freedom of choice • Comparability • Statewide • Program may not be capped at a set number of participants
HCBS Settings Rule	Must be met	Must be met

The two options offer different opportunities to expand access to HCBS. The 1915(k) would have the same level of care criteria as the current 1915(c) (institutional level of care). To the extent that existing 1915(c) services can be provided under a new 1915(k) instead, the additional federal match frees up state dollars to enhance the service package or make other access improvements in Maine’s LTSS system. Retaining the existing level of care makes the target group predictable—it will be nearly identical to the target group served under the existing 1915(c).

The 1915(i) offers the ability to decouple the HCBS level of care from the existing nursing facility level of care. This is appealing because Maine’s institutional level of care is relatively high. A high level of care is appropriate for nursing facilities, but it has the effect of keeping people with lower levels of care from accessing home care through the 1915(c) waiver program. This is likely why Maine’s 1915(c) waiver program for older adults has never had a waiting list, unlike the state-funded home care program, which includes lower levels of care. A 1915(i) would enable the State to access MaineCare funding for people at lower levels of care, and perhaps relieve pressure from the state-funded home care program. However, without more careful analysis, it is difficult to

predict how many new people would access HCBS under a 1915(i), since state plan options cannot be capped.

Given that any new program will take time and effort from the Department and service providers to implement, the Department should proceed with developing a 1915(k) option first, since it offers opportunities to expand access with little downside risk. Once the 1915(k) is implemented, the Department should revisit whether or not to implement the 1915(i) option as well.

In either option, the Department should make the new service more flexible for participants by reviewing task time allowances to support member flexibility and choice within their person-centered plan.

Recommendation: Expand the use of Assistive Technology (AT) and environmental modifications to make home care feasible for more people, enable people to live more independently, and increase the efficiency of home care staffing.

The enhanced federal financing available through Section 1915(k) offers the opportunity to enhance HCBS services by adding service options or expanding service limits. One area of investigation for the Committee was how to expand the use of AT to enable more individuals to stay at home and live more independently while also making home care staffing more efficient given the workforce shortage. AT devices encompass a broad range of products that improve a person's ability to live and function independently. It includes low-tech devices such as canes and pill organizers and high-tech applications such as sensors and smart phone systems.

During September's Committee meeting, a panel of subject matter experts were asked to address three areas: The panel 1) provided examples of how AT currently supports older adults and adults with physical disabilities to remain in their homes, 2) identified some of the current challenges in accessing or providing AT services, and 3) offered suggestions to overcome these challenges.

Suggestions generated from this panel included:

- Streamline the application process to enable AT providers to apply time for all MaineCare services, waivers, and State Plans that offer this service;
- Consider bundling service limits for environmental modification and AT to increase access to services; and,
- Recommend increased hours of annual training on AT devices from eight hours to 15.

The Department should address these changes to AT as it develops its Section 1915(k) option and apply the changes to other similar MaineCare services as well. The Department should also examine how access to AT can be expanded within the Older Americans Act and state-funded programs in the 2020-2024 State Plan on Aging.

Recommendation: Strengthen Maine LTSS information and referral system (No Wrong Door).

Despite years of publicizing toll-free numbers at the Area Agencies on Aging (AAAs) and implementing Aging and Disability Resource Centers (ADRCs) within the AAAs, families continue to report challenges with identifying resources when they need help. This concern was expressed by Committee members and reinforced by citizens who attended the State Plan on Aging listening sessions. Home care is less visible to the public than nursing facilities, and until a family needs LTSS, they typically do not know what home care offers or how to access it. A key strategy to expand access to home care is making it easy to find.

Three potential areas of enhancement identified during the listening sessions were:

- Work with the five AAAs to identify specific strategies for making their services more visible and accessible;
- Provide resources to municipalities through age-friendly community networks and the Maine Municipal Association; and
- Revisit the feasibility of an electronic application that connects adults to the services that they may be eligible to receive and streamlines the eligibility process.

The Department should consider ways to finance enhancements to its information and referral system. Options may include using a portion of the expanded federal financing under Section 1915(k) and potential increases in Maine's Older Americans Act funding and other federal grant programs, pending reauthorization of those programs by Congress.

Recommendation: Make LTSS care coordination more efficient and effective.

Good care coordination is key to positive consumer experience, contributes to quality outcomes and helps prevent avoidable hospitalization and nursing facility admissions. Maine's case management and care coordination have evolved over time, with different definitions, limits, and payment methods applied from program to program. In many programs, care coordination stops at the boundary of the service in which it is provided,

limiting its value and making it difficult to be person-centered. For example, a person receiving home care may also be participating in a health home that manages chronic conditions, such as diabetes or high blood pressure, but the LTSS case manager's responsibilities do not officially include coordination with the health home. The case management agency is not reimbursed when a case manager participates in an interdisciplinary team meeting convened by the health home.

The care coordination role for LTSS services as currently defined in rule does not include identification of needs outside LTSS, such as medical or educational. If an LTSS participant is accessing those services through another venue, such as a Health Home, there is no mechanism to coordinate with the other venue.

The current structure of LTSS care coordination payment requires quarter hour billing with limits per member, and a narrow definition of what will be reimbursed. The Advisory Committee discussed the need to broaden the scope of care coordination and the method of reimbursement. As the Department designs the 1915(k) service, it should consider implementing a bundled payment for care coordination, in which a Per-Member-Per-Month (PMPM) fee would be paid instead of quarter hour reimbursement. The bundled rate would be calculated at the average cost per member of the service, but the provider would have flexibility to conduct more coordination for more complex members and less for less complex members. The scope of the service could be expanded to include participation in Interdisciplinary Care Teams (IDTs) and interaction with other agencies outside LTSS, and the bundled rate could be tiered based on population rates. One or more quality measures would be implemented and tied to payment to make clear the policy objectives of the change, which may include better consumer experience and better outcomes.

The Committee also recommended consistency in care coordination rates and service definitions across programs, where practical and appropriate. In some cases, the differences may be deliberate. Health Homes, for example, are explicitly expected to manage chronic conditions. Unless a reason exists for the differences, however, the Department should review case management and care coordination definitions and payment rates across programs and make them uniform when possible. Doing so will make it easier for the Department to communicate coordination expectations across programs, make programs easier for care coordination agencies to administer, lead to a more consistently positive experience for participants, and improve system efficiency.

Recommendation: Streamline service delivery across similar programs.

In addition to making care coordination more consistent across programs, the Department should consider merging certain closely-related programs to simplify choice for participants and ease administration for providers and the Department.

Within the State of Maine's provision of services for older adults and adults with physical disabilities there are three main funding streams:

- MaineCare HCBS waiver and State Plan services and programs;
- OADS State-funded programs for at-risk groups who do not currently qualify for similar MaineCare services; and
- Federally-funded programs through the Older Americans Act.

A preliminary analysis of programs identified the potential to align the following programs to create a more efficient, effective, and understandable process for members:

- Combine MaineCare Section 96, Private Duty Nursing (PDN),¹ and Section 12, Consumer Directed Attendant Services,²; and
- Combine State-funded Section 63, Home-Based Care,³ and Chapter 11, Consumer-Directed Home-Based Care.⁴

¹ 10-144 CMR Chapter 101 (MaineCare Benefits Manual) Chapter II § 96

² 10-144 CMR Chapter 101 (MaineCare Benefits Manual) Chapter II § 12

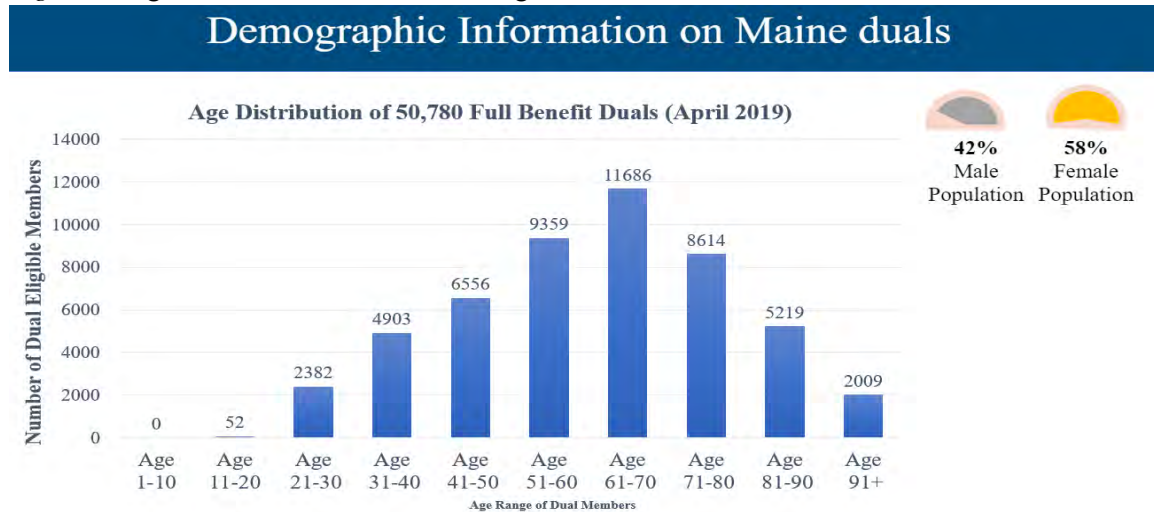
³ 10-149 CMR Chapter 5 (Office of Aging and Disability Services Policy Manual) § 63

⁴ 14-197 CMR (Office of Aging and Disability Services Policy Manual) Chapter 11

Focus Area 2: Strengthening Coordination for Beneficiaries with Medicare and MaineCare (Dual Eligible Individuals)

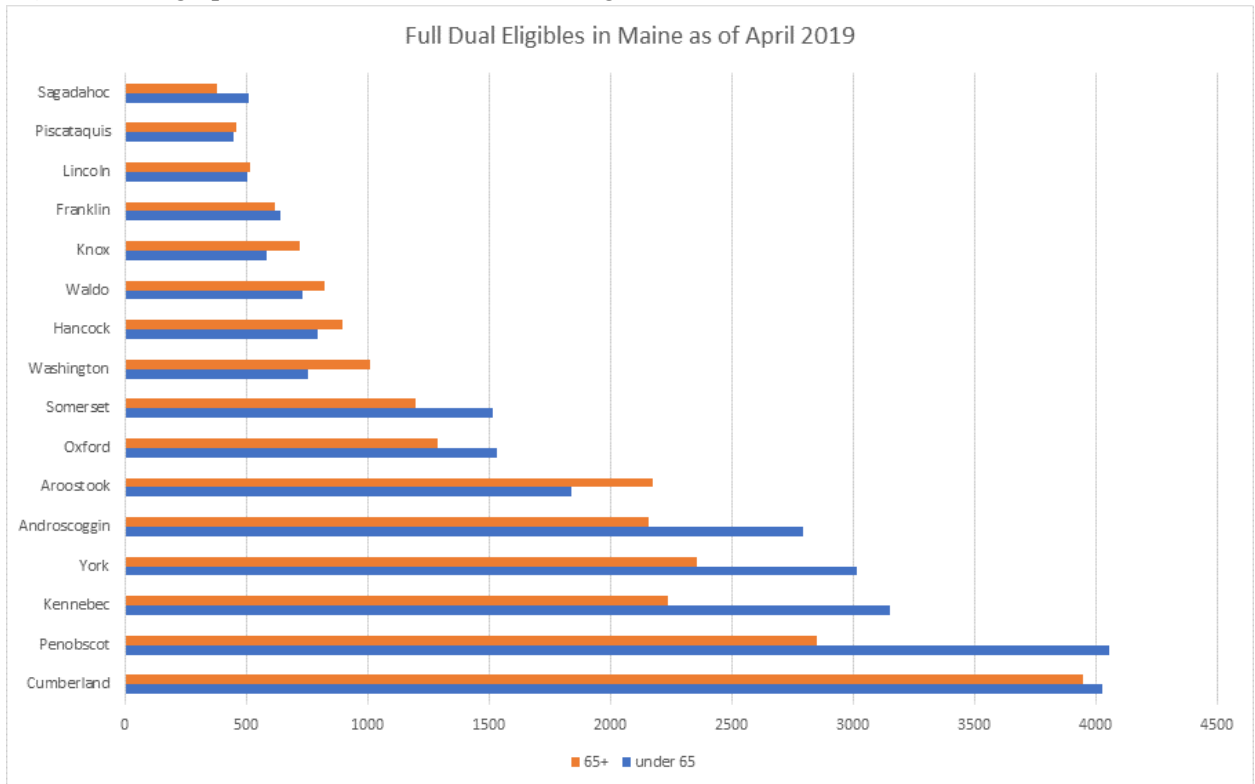
Dual eligible individuals or (“duals”) have both Medicare and MaineCare insurance. Partial dual eligible individuals have limited MaineCare insurance through the Medicare Savings Program (MSP) that only helps pay for Medicare cost sharing expenses. Full dual eligible individuals have full MaineCare coverage that includes both help with Medicare cost sharing expenses and access to MaineCare covered services. Approximately 51,000 Maine citizens are full dual eligible individuals, with half age 65 or older (Figure 4). People under 65 access Medicare through the Social Security Disability Insurance (SSDI) program. Once found eligible for SSDI, they obtain Medicare after a two-year waiting period. Those individuals 65 and over become eligible for Medicare if they qualify for Social Security or Railroad Retirement benefits.

Figure 4: Age Distribution of Full Dual Eligible Individuals in Maine



Dual eligible individuals are distributed throughout Maine (Figure 5). For the most part, the distribution correlates to population, with the most populous counties having the greatest number of dual eligible individuals. Other factors influencing the number of duals include poverty rate and number of people who are 65 and older in a county.

Figure 5: Geographic Distribution of Full Dual Eligible Individuals in Maine.



Dual eligible individuals navigate two major insurance coverages. Medicare is the first payer for most preventive, primary, acute services, and for prescription drugs. MaineCare is the payer for LTSS, certain behavioral health services not covered by Medicare, and Medicare beneficiary cost sharing expenses. In most cases, the medical, behavioral, and LTSS service systems operate separately from one another with LTSS providers often unaware of transitions of care (admissions, transfers, and discharges from hospitals and other facilities). As noted earlier in this report, the scope of LTSS care coordination generally does not include coordination of physical or behavioral health services, so members and their families are often the ones who must connect the dots among multiple providers and sources of insurance coverage. The Committee considered ways to address the following goals related to dual eligible individuals:

1. Improve consumer experience and outcomes;
2. Improve provider experience;
3. Capture Medicare savings; and
4. Improve State system infrastructure for Medicare-MaineCare coordination.

Opportunities for State-Federal Partnership

The federal Centers for Medicare and Medicaid Services (CMS) sponsored a Medicare-Medicaid financial alignment initiative from 2013 in which 13 states participated.⁵ The demonstrations included capitated models, in which a managed care organization became a Medicare-Medicaid Plan (MMP) and was responsible for all Medicare and Medicaid services of those enrolled. The demonstration also included a managed fee-for-service model, in which designated entities, such as Health Homes, were responsible for managing all Medicare and Medicaid services on a fee-for-service basis. Early evaluation findings have been promising, and CMS has now made these models and related strategies available to all states.⁶ Although no grant funding is available for program development, the models are nonetheless worth further investigation as vehicles for improving coordination while allowing the State to capture potential Medicare savings that accrue from prevention of unnecessary hospitalization and other high cost services.

The Committee reviewed both approaches and found potential advantages and challenges to each one (Figure 6).

Figure 6: Advantages and Challenges in Maine of Alignment Models for Dual Eligible Individuals

	Managed Fee-For-Service	Capitated Managed Care
Advantages	<ul style="list-style-type: none"> • Could build on existing MaineCare Health Homes/Accountable Communities experience and infrastructure through partnerships with AAAs and LTSS providers • If Medicare savings accrue, State would receive 50% 	<ul style="list-style-type: none"> • Could build on existing Dual Eligible Special Needs Plans (D-SNPs) • MMPs can offer extra Medicare benefits • Anticipated shared CMS-State savings are built into capitated rate
Challenges	<ul style="list-style-type: none"> • State must invest in the model with no guarantee of accrued Medicare savings • Few LTSS providers currently share data through Maine HealthInfoNet, which may make data sharing with 	<ul style="list-style-type: none"> • MaineCare does not currently have infrastructure to develop and monitor capitated managed care • Maine D-SNPs do not appear to have strong relationships with

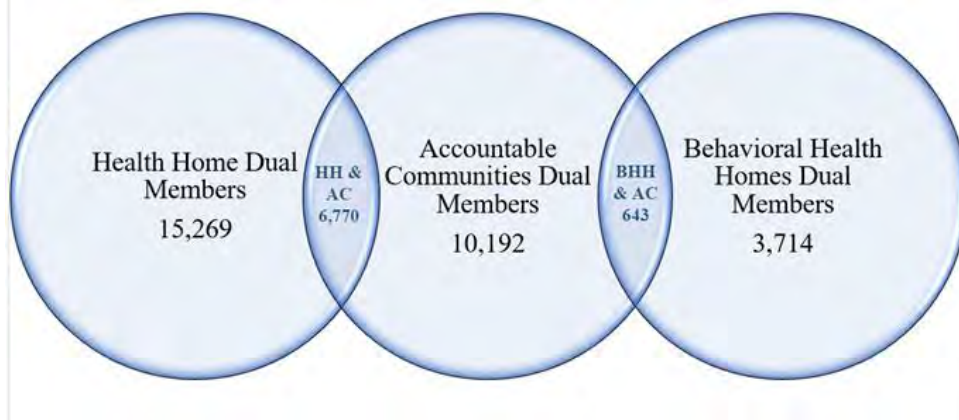
⁵ See *Financial Alignment Initiative for Medicare-Medicaid Enrollees*. <https://innovation.cms.gov/initiatives/Financial-Alignment/>

⁶ See CMS State Medicaid Directors Letter #18-012: *Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare*. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf>; and CMS State Medicaid Directors Letter #19-002: *Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare*. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19002.pdf>

	<p>Health Homes and Accountable Communities challenging</p> <ul style="list-style-type: none"> • CMS estimates that nearly half (24,000) of Maine’s full dual eligibles are already attributed to a Medicare Shared Savings ACO, making them ineligible for shared federal-state savings 	<p>LTSS providers and other community-based organizations</p> <ul style="list-style-type: none"> • Some consumers are wary of managed care plans
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Maine has existing service delivery infrastructure that could support either model. MaineCare operates managed fee-for-service programs as part of its Value-Based Purchasing strategy, and each of these includes dually eligible individuals. Health Homes enroll MaineCare members with chronic conditions, Behavioral Health Homes enroll members with serious mental health needs, and Accountable Communities enroll MaineCare members who seek most of their primary care through practices within the Accountable Communities. Because some practices operate Health Homes within Accountable Communities, membership in the programs overlap (Figure 7).

Figure 7: Dual Eligible Individuals in MaineCare’s Existing Managed Fee-for-Service Programs



Currently, although these programs serve dual eligible individuals and may be achieving reductions in Emergency Department use and hospitalizations which result in cost savings for Medicare, MaineCare does not benefit from these savings. In partnership with CMS, the State could share in these Medicare savings. However, savings are not guaranteed, and the State would need to invest in the expanded coordination up front. Also, the State would not be able to capture Medicare savings from dual eligible individuals who are already attributed to a Medicare Shared Savings Accountable Community Organization (ACO). CMS has estimated that about half of Maine’s full dual eligible individuals are in Medicare Shared Savings ACOs.

The State also has service delivery infrastructure for a capitated managed care model. Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage Plan that

enroll only dually eligible individuals. Although they are overseen and paid for by the federal Medicare program, they must have an agreement with the state Medicaid agency in order to offer their plan in a state. In 2019, MaineCare had relationships with four D-SNPs with about 9,000 dual eligible individuals enrolled. A fifth D-SNP will be operating as of January 2020 (Figure 8).

Figure 8: D-SNPs Operating in Maine.

D-SNP	Availability	Parent Company
Symphonix Health Insurance	Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Waldo, York	United HealthCare
Arcadian Health Plan	Androscoggin, Cumberland, Knox, Oxford, York	Humana
Empire Healthchoice HMO	Androscoggin, Aroostook, Cumberland, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Sagadahoc, Somerset, Waldo, York	Anthem
Wellcare of Maine	Androscoggin, Aroostook, Cumberland, Hancock, Penobscot, York	Centene (acquisition in progress)
Aetna	Available statewide beginning January 2021	CVS

The Department has begun the process of assessing interest among Health Homes and Accountable Communities, and D-SNPs and other managed care plans, in developing integrated models for dually eligible individuals. As part of forums held with Health Homes and Accountable Communities, MaineCare is discussing these providers' experience with and interest in coordinating LTSS services. In October 2019, the Department issued a Request for Information (RFI) to existing D-SNPs and other managed care organizations and associations to learn about their experience with and interest in Medicare-Medicaid integrated care models. Four of the five D-SNPs in Maine and three other managed care organizations responded. The Department is analyzing the responses.

Recommendation: Continue to study options to strengthen coordination for dual eligible individuals, including managed fee-for-service models that build on Maine's Health Homes and Accountable Communities, and capitated managed care models with Medicare-Medicaid Plans (MMPs), D-SNPs or other accountable entities.

The Committee saw significant potential to improve experience and outcomes for dual eligible individuals while improving cost effectiveness in both models. The complexity of integrating care across two major insurance coverages, one federal and one state, requires more study before a specific model can be recommended. The Department should continue to explore the feasibility of both fee-for-service and managed care models, while looking for opportunities to increase provider awareness and competency to serve dually eligible through education and cross-training.

Recommendation: Strengthen data integration, analysis and sharing infrastructure.

CMS has increased the amount and types of Medicare data available to state Medicaid programs. COBA data, for example, is enhanced Medicare claims data made available within a few weeks of the claims being submitted by providers. Several states have used this data to create person-level linked Medicare-Medicaid files, which provide a comprehensive picture of the total needs of dual eligible individuals. Such files are invaluable for planning integrated programs. The Department should increase its capacity to receive, link, and use such data as it continues to plan for integrated programs.

At the provider level, a key to integrating care is sharing data about common patients in real time. Maine's health information exchange program, HealthInfoNet, serves as the vehicle for this exchange. In addition to making claims available across providers, HealthInfoNet offers a service that notifies providers when their patients are admitted or discharged from hospitals. Such information is key to integrating primary care, acute care, and LTSS, but relatively few LTSS providers currently participate in HealthInfoNet. Federal funding is available to develop the infrastructure for LTSS providers to participate, and the Department should consider pursuing it. This would build critical data sharing infrastructure for integrated care, regardless of which models develop in the state.

Recommendation: Update the Department's contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) to strengthen coordination between Medicare and MaineCare and conform with new federal requirements that take effect in 2021.

D-SNPs are a potential vehicle for integrating Medicare and MaineCare services. Currently in Maine, they are responsible for the cost of only Medicare services, but they are required to serve and coordinate care for dual eligible beneficiaries and maintain an agreement with MaineCare for this purpose. Changes in federal law requires D-SNP agreements with Medicaid agencies to include stronger coordination requirements for

identified high-risk enrollees as of January 1, 2021.⁷ The new federal requirements offer an opportunity for the Department and D-SNPs to strengthen the current agreement while also exploring the feasibility of a more significant partnership in which D-SNPs could potentially take responsibility for MaineCare services.

Conclusion

The recommendations in this report represent first steps in reforming Maine Aging and LTSS system to ensure access to high quality services as Maine's population ages. In the short term, development of a Section 1915(k) State Plan Option for HCBS offers the opportunity to improve the effectiveness of services with enhanced federal matching funds. The State also has opportunities to strengthen infrastructure for integrating Medicare and MaineCare services while it continues to assess the feasibility of both fee-for-service and managed care models.

⁷ See CMS Informational Bulletin: *Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for State Medicaid Agency Contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) for Contract Year 2021*. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib111419-2.pdf>