Title: Access to Home-and-Community-Based Services among Duals with Alzheimer's Dementia: Does Plan Integration Matter?

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ABSTRACT

Background: Alzheimer's dementia and Alzheimer's related dementias (ADRD) account for a growing share of health care spending among dually eligible Medicare-Medicaid enrollees (i.e., among duals). Approximately 400,000 Medicare beneficiaries with diagnosed ADRD are dually eligible for Medicaid benefits. Duals account for a third of all ADRD diagnosed beneficiaries in Medicare but nearly half of the $250 billion that Medicare and Medicaid spend annually on services for persons with dementia. Medicare and Medicaid are each responsible for a separate component of care needed by duals with dementia; Medicare covers medical care, including home health and durable medical equipment, while state Medicaid programs have been using Home and Community-Based Services (HCBS) waivers from CMS (the Centers for Medicare and Medicaid Services) to fund social supports that individuals with progressive dementia need once their functioning becomes too impaired to perform instrumental activities of daily living. The separate administration of duals' Medicaid and Medicare benefits, respectively, often results in fragmented services coordination among duals and in a misalignment of financial incentives between duals' Medicare and Medicaid plans. This study tests whether access to Medicare and Medicaid services needed by many duals with ADRD is improved by enrolling in a special category of Dually Eligible Special Needs Plans (D-SNPs) that brings together duals' federal Medicare and state Medicaid coverage under one comprehensive Medicare-Medicaid health plan operated by one managed care organization (MCO).

Conceptual Framework. Dually Eligible Special Needs Plans (D-SNPs) are Medicare Advantage plans that enroll only duals. Integrated D-SNPs in this project are defined as D-SNPs that offer aligned and integrated plan enrollment, which means: (i) everyone in the integrated D-SNP is also enrolled in the same state Medicaid managed care plan operated by the same MCO; and (ii) the MCO must align and integrate the (normally) separate Medicare and Medicaid benefit plans into one comprehensive plan, including benefit guides, care coordination for HCBS and medical care coordination, and beneficiary grievance review, among other features. This arrangement is enforced by a three-way contract between the MCO, the state Medicaid agency, and CMS.

In our conceptual framework, integrated D-SNPs' integration of duals' Medicare and Medicaid benefits would be expected to result in their enrollees having greater access to services that support people with ADRD who live in community residences and not in nursing homes or other institutional residential settings. The reasoning behind this hypothesis is the misalignment of financial incentives that is inherent to non-integrated D-SNPs, wherein Medicaid long-term care services are not a covered benefit and must be separately coordinated. In this scenario, the Medicare provider organization has no financial incentive to manage prevention of unnecessary nursing home stays or to coordinate access to needed Medicaid HCBS. Types of Medicaid HCBS vary but typically include personal care services (e.g., housekeeping, meals, non-medial transportation), adult day and respite care, and nursing home residency for those who need 24-hour institutional care. Meanwhile, Medicaid does not pay for duals' hospital care and consequently duals' Medicaid insurer has weak financial incentives to avert transfers to hospitals for emergency or acute inpatient care.

Data and Sample. Administrative Medicare and Medicaid data were obtained for duals with full Medicaid coverage who had an ADRD diagnosis in the 2021 Master Beneficiary Summary File. The sample was limited to duals residing in one of six states where both integrated and non-integrated D-SNPs were being offered (California, Florida, New York, Tennessee, Virginia, and Wisconsin). The final data sample contained N=31,297 observations, n=2,562 in integrated D-SNPs and n=28,375 in non-integrated D-SNPs. Using this 6-state sample, we applied entropy balancing to construct inverse probability weights that balanced individual and county characteristics between the integrated and non-integrated D-SNP groups, respectively. Covariates used in balancing included demographics, chronic conditions, ADRD diagnosis year, Medicare

plan type in 2020, area type, inpatient hospital utilization in 2020, and county-level measures that included urbanicity, nursing home bed supply, and home health workforce size.

Measures. We compared access to needed Medicaid HCBS and Medicare GUIDE-model medical care coordination services between integrated and non-integrated D-SNPs. Study outcomes were binary indicators of any service use during 2021 in the following categories: Medicaid-funded supports for community living including daily living supports, home health devices/equipment/modifications, skilled home healthcare, day/respite care, and residential care; and Medicare-funded medical care management services including wellness visit, depression screen, advance care planning, chronic care management, transitional care management, and oversight of home health/hospice.

Results. In weighted analyses that compared service use between the integrated and non-integrated D-SNP groups, beneficiaries enrolled in integrated D-SNPs had greater use of home health devices/equipment/modifications (34.5% vs 23.6%; *p*-value<.001) and chronic care management (11.2% vs 8.8%; *p*-value<.001), and lower use of annual wellness visits (36.6% vs 43.1%; *p*-value<.001). Use of other types of services did not differ by plan integration. sensitivity analysis that was restricted to beneficiaries residing in counties where integrated D-SNPs were offered found similar results. Results were also robust to alternative model specifications (e.g. adding covariates and using state-level clustered standard errors) and adjustment for multiple comparisons.

Conclusions: Findings indicate that among duals with ADRD, integrated D-SNPs resulted in greater use of home health equipment and chronic care management services and lower use of wellness visits. These effects suggest that integration of duals' Medicare and Medicaid benefits under one MCO resulted in improved access to services associated with medical management and community-based in-home supports.

Keywords: Alzheimer's disease and related dementias; Integrated Dual Eligible Special Needs Plans; Home and community-based care; Medical care management; Medicare and Medicaid

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