

**National MLTSS Health Plan Association
Proposals to Advance Integrated Plans**

A Common Framework for Integrated Plans

The Association supports creating a common statutory and regulatory framework that would apply to all plans that integrate Medicare and Medicaid coverage for individuals who are eligible for both (Dual Eligible beneficiaries). We recognize the roles of the Federal government and the states will need to be delineated to take advantage of existing capabilities and infrastructure. The framework would accommodate various “modalities” of integrated plans that may retain unique features needed to continue to serve specific subpopulations.

Integrated Plan Regulation

The authority of the existing Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare and Medicaid Services (CMS), which currently oversees the Medicare-Medicaid Plans (MMPs) created in the Financial Alignment Initiative, would be expanded to include all plans that integrate Medicare and Medicaid benefits or are components of integrated plans.

Integrated Modalities

The Association supports retaining the range of integrated modalities that exist and working to advance integrated approaches wherever possible. Integrated models should be the preferred option in states that have Medicaid managed long-term services and supports (MLTSS). Congress would:

- Permanently reauthorize all SNPs, including D-SNPs.
- Make MMP a permanent option -- States with existing MMPs would have the opportunity to further modify them to incorporate learnings from the Financial Alignment Initiative (FAI) Demonstration – States without existing MMPs could adopt a new MMP model reflecting learnings from the FAI Demonstration. CMS would encourage wider adoption of MMP by states.

Uniform Regulatory Structure

A uniform regulatory structure would provide a level playing field between various modalities, and not create incentives to choose one model over another. The common framework should include uniform

- appeals and grievance,
- marketing, enrollment process,
- claims reporting,
- rate-setting, and
- risk adjustment.

Contract Structure

Integrated plans would be regulated and compensated through the mechanism of a three-way contract between CMS, the State Medicaid agency and the plan to foster effective communication between regulators and the plan, provide administrative flexibility, and ensure proper alignment of incentives to achieve the best outcomes.

Enrollment

The Association supports moving toward integrated approaches, initially for all individuals who have dual eligibility for Medicare and Medicaid, and eventually for individuals with LTSS needs who are not eligible for Medicaid. Members with dual eligibility are more likely to achieve better health outcomes and quality of life in an integrated environment.

The Association supports allowing states to require dual eligible beneficiaries to be in an integrated, managed environment (either plan or provider led). Not all States offer MLTSS or integrated plan options. At a minimum, those States should be able to require enrollment of all dual beneficiaries in a D-SNP. States that are moving to MLTSS should provide adequate time and transition for pre-existing D-SNPs to develop an integrated option or align with an MLTSS plan.

States that have Medicaid MLTSS and have integrated or aligned options available should have the authority to require that dual eligible beneficiaries enroll in an integrated plan (a FIDE-SNP, MMP, or PACE plan or an aligned D-SNP and MLTSS plan). Dual eligible individuals should have a choice of which integrated plan to enroll in, and should only be passively enrolled when no choice is made. Individuals enrolled in a plan should remain enrolled in that plan until the next open enrollment period, with continuous coverage of existing providers during this period. Individuals could dis-enroll at any time for cause, which would include loss of key providers and inadequacy in the provider network for the individual's disabilities.

Flexibility of Benefits

Integrated plans should have flexibility to provide appropriate services and supports that meet the needs of the beneficiary, whether specified as benefits under Medicare or Medicaid or not.

Medicare should allow integrated plans the flexibility to determine the services and supports that are available under the plan without being subject to the distinction in Medicare between covered and supplemental benefits, the Medicare Advantage bid process for benefit descriptions, or the limits created by having to be “medically necessary,” “related to,” or “in lieu of” medical services.

Integrated plans should be able to report in a patient-centric manner, and not be required to disaggregate discrete units of Medicare and Medicaid services and supports that were provided holistically.

Payment

Federal and state payment for individuals enrolled in integrated plans should be combined in a single capitated or per member per month (PMPM) amount that is transparently set and actuarially sound. Payments that cover the same member should not be disaggregated.

Rate Setting

Federal payment should be determined by actuarially-sound, accurate, and transparent formulas that take into account the unique health care needs of the dual eligible population.

Payment Structure

Payments should incentivize HCBS alternatives to institutions.

Risk Adjustment

Payments should include risk adjustment based on member functional and cognitive capabilities (including dementia) and behavioral, medical, and/or demographic characteristics rather than the eligibility category and setting or location of care. Risk adjustment should be standardized across models.

Shared Savings

Plans, the federal government, and state government should share savings the plans generate from managing integrated plans. When states first implement integrated plans, they should provide risk corridors that would protect both states and plans from rates that either over- or under-estimate

actual costs due either to a lack of experience with the population or a spike in demand from new coverage.

States should be able to share in savings to Medicare spending attributable to the operation of the integrated plan and be allowed to spend savings on any service, including Medicaid.

Quality Measurement

Integrated plans should be accountable not only for members' health outcomes, but also for members' quality of life and satisfaction, particularly with regard to non-medical services and supports provided by the plan.

The existing STAR Rating system for MA plans is focused on the quality of medical services provided to Medicare beneficiaries as a whole. It does not adequately measure or rate quality when it comes to populations that have high concentrations of dual-eligible beneficiaries or persons with LTSS needs.

- CMS should modify the STAR Rating system to take into account low socioeconomic status (SES) of plan members and the proportion of dual-eligible members in the plan.
- Integrated plans should not be rated and rewarded solely on the basis of the medical STAR Ratings but should also be measured on non-medical and qualitative issues, such as member quality of life and satisfaction, that are relevant to members receiving LTSS.