National
MLTSS
Health Plan Association

A Proposal to Advance Integration for Dual Eligible Beneficiaries

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Background

Today only 9 percent of "full-benefit Duals" (beneficiaries who have full coverage in both Medicare and Medicaid) are enrolled in managed care plans that integrate their Medicare and Medicaid coverage.[1] The remaining "full Duals" are enrolled in separate Medicare and Medicaid coverage and must navigate a complex and confusing world of overlapping coverage and disconnected services. This fragmented care for dual eligible individuals delivered by unaligned fee-for-service (FFS) systems results in greater administrative burdens, higher costs,[2] greater beneficiary confusion, and significant gaps in quality of care.[3] In 2018, Congress and the Centers for Medicare and Medicaid Services (CMS) acted to expand the availability of integrated Medicare and Medicaid coverage for beneficiaries who are eligible for both programs.

As part of the Balanced Budget Act of 2018 (PL 115-124), Congress enacted several significant changes in the requirements for Medicare Advantage (MA) Duals Special Needs Plans (D-SNPs) to coordinate with state Medicaid programs to integrate Medicaid coverage for long-term services and supports (LTSS). The major advances detailed in the proposed rule that CMS published to implement the Act[4] were:

- Permanent authorization for D-SNPs.
- Minimum standards of Medicaid integration that will apply to D-SNPs – with three possible levels of integration:
    1) A D-SNP with state Medicaid contract that does not include LTSS and behavioral health (BH) services. In these cases, a D-SNP must notify the state of hospital or SNF admissions for one group of high-risk duals (as defined by the state);
    2) Highly-Integrated Dual-Eligible SNP (HIDE-SNP) – a D-SNP that has a state Medicaid contract that includes LTSS and BH services. The HIDE-SNP may be either "exclusively aligned" (enrollees must be in the same organization's Medicare and Medicaid plans) if the state requires it, or aligned or unaligned; and

[1] CMS Medicare-Medicaid Coordination Office. People Dually Eligible for Medicare and Medicaid. Fact Sheet, March 2019. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf

[2] Duals are 20% of Medicare enrollees and 15% of Medicaid enrollees and consume 34% of Medicare spending and 33% of Medicaid spending, respectively.

[3] CMS, Medicare-Medicaid Coordination Office. "FY2017 Report to Congress." June 2018. And Medicare Payment Advisory Commission (MedPAC). "Report to the Congress: Medicare and the Health Care Delivery System, Chapter 9: Managed Care Plans for Dual-Eligible Beneficiaries." June 2018.

[4] CY2020-2021 Proposed Policy and Technical Changes to the Medicare Advantage Program CMS-4185-P

3) Fully-Integrated Dual-Eligible SNP (FIDE-SNP) – a D-SNP that has a contract with the state to cover all Medicaid benefits, and has enrollment limited to full benefit duals who are "exclusively aligned."

- Better unified appeals and grievance processes across Medicare and Medicaid for D-SNP members.
- Expanded role for CMS's Medicare and Medicaid Coordination Office (MMCO) to serve as a dedicated point of contact for states on integration.

The Balanced Budget Act provisions create a pathway for states to advance toward full integration. While they provide clearer direction on what is needed to achieve various "levels" of integration, they do not make major changes that would accelerate the move toward integration. Many of the challenges and impediments to integration remain in place and will require additional regulatory action and legislation if more states are to move toward full Medicare-Medicaid integration.

This paper proposes a series of regulatory and legislative changes to address barriers to integration and improving the integrated model for dually eligible beneficiaries, and outlines a recommended strategy for advancing and growing the enrollment of dually eligible individuals in an integrated model.

National MLTSS Health Plan Association

An Improved Integrated Model

A. Common Framework for Integration

Barriers	Recommendations
Unnecessary Complexity/Lack of Clarity of Alternative Models	A Common Statutory and Regulatory Framework
The variation in models for integrated plans is far greater than is warranted by actual differences in what the models do. The models – Medicare-Medicaid Plan (MMP), FIDE-SNP, HIDE-SNP, D-SNP with MIPPA/SMAC contracts, and PACE -- are regulated under different sections of federal statute and consequently have arbitrarily different statutory and regulatory requirements. They all integrate Medicare and Medicare coverage and payment, oversee similar care models, and cover similar high-need populations. The variations in marketing requirements, enrollment approaches, appeals and grievance procedures, and payment/risk adjustment policies cause confusion, create incentives for adopting one model over another, and do not better serve the needs of dual-eligible beneficiaries. In creating 3-tiered minimum standards for D-SNPs, proposed rules implementing the BBA added to the complexity by labeling new types of integrated plans with varying degrees of alignment.	The Association supports creating a common statutory and regulatory framework that would apply to all plans that integrate Medicare and Medicaid coverage for dual eligible individuals. We recognize that the roles of the Federal government and the states will need to be delineated to take advantage of the existing capabilities and infrastructure of each partner. The framework should accommodate various "modalities" of integrated plans that may retain unique features needed to continue to serve specific subpopulations of dual eligibles (e.g., individuals with intellectual and developmental disabilities). A Federal Regulatory Agency for Integrated Plans The BBA strengthened the role that the existing Medicare-Medicaid Coordination Office (MMCO) within CMS plays with regard to integrated plans. While essential Medicare and Medicaid regulation should remain under separate authorities administered by distinct CMS units, as a common statutory framework is developed for integrated plans, the principal regulatory authority for this framework and the plans encompassed within it should be assigned to MMCO, with required coordination with CMS's Medicare and Medicaid units.

	<u>Integrated Modalities</u> The Association recommends a common framework that accommodates the current range of integrated modalities and encourages advancement toward greater integration. A fully integrated model should be the preferred option in states that have Medicaid managed long-term services and supports (MLTSS). Other states should be provided incentives to adopt a more integrated approach. The Association recommends that Congress permanently authorize an improved version of the MMP that incorporates learnings from the Financial Alignment Initiative (FAI) and recommendations from this Association. The revised MMP would be the basis for the common framework. States that have participated in the FAI could transition to the new model. CMS would encourage other states with integrated models to adopt the new MMP or make revisions to their existing models that would improve their alignment with the common framework. <u>Uniform Regulatory Structure</u> 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 rules governing: • appeals and grievance, • marketing, • enrollment, • claims and encounter reporting, • rate-setting, and • risk adjustment. The BBA of 2018 called for a unified appeal and grievance process and set of rules for integrated plans, but deferred to the

	HHS Secretary to develop these. As these rules emerge, they will create a starting point for reviewing options for consolidating other requirements for MA and Medicaid plans.
Loose Definition of Integration	Tightened Definition of Integrated Plans
Current regulations and the proposed rule implementing the BBA 2018 statute[5] that is aimed at encouraging more integration allow D-SNP plans to be considered "integrated" even when they do little to contract and coordinate care with the state Medicaid program that covers their enrollees. As a result, many states will continue to allow enrollment of dual eligible Medicaid beneficiaries in D-SNPs that do not meet CMS integration standards.	The Association supports the policy enacted in the BBA that all D-SNPs must integrate coverage and services with Medicaid at some acceptable level (as further specified in regulation[6]) prior to 2021. Beginning in 2021, all D-SNP plans will have to meet the statutory and regulatory requirements for integration. The Association believes that these requirements are appropriate for "full dual eligible" D-SNP enrollees[7] but not for "partial dual eligible" enrollees, whose Medicaid coverage is limited to paying Medicare copayments. Since no Medicaid services are provided to "partial duals," they should be enrolled in a different form of MA plan that does not seek coordination with Medicaid services. Further, the Association acknowledges that many states may not adopt MLTSS and, therefore, D-SNPs in those states will need to integrate with the state's Medicaid FFS program and coordinate coverage and services through a MIPPAA contract with the state Medicaid agency. In the proposed rule implementing the BBA provisions,[8] CMS establishes an "affirmative duty" for a D-SNP to arrange for Medicaid benefits for enrolled members. The

[5] CY2020-2021 Proposed Policy and Technical Changes to the Medicare Advantage Program CMS-4185-P
[6] CY2020-2021 Proposed Policy and Technical Changes to the Medicare Advantage Program CMS-4185-P
[7] "Full dual eligible" enrollees receive all Medicaid benefits not covered by Medicare (including LTSS and behavioral health care) through the Medicaid program. "Partial dual eligible" beneficiaries only have their Medicare cost sharing liabilities (including premiums, deductibles, and coinsurance) covered by the Medicaid program.
[8] CY2020-2021 Proposed Policy and Technical Changes to the Medicare Advantage Program CMS-4185-P

	Association believes that the duty to arrange for benefits should, at a minimum, include a duty to confirm that members are enrolled in Medicaid and able to receive Medicaid benefits. In addition, the "affirmative duty" should include specific requirements for D-SNPs to share data and coordinate care with the state Medicaid agency and any providers of Medicaid-covered services to its enrollees. The Association also recommends that CMS, through its Center for Medicare and Medicaid Innovation (CMMI), invest in developing and testing models for administrative coordination, information system interoperability, care management, and accountability aimed at improving the seamless operation and experience of care for dual eligible beneficiaries in states that integrate D-SNP and fee-for-service Medicaid. <u>Three-Way Contract Structures</u> The Association recommends providing for regulation and compensation for all integrated plans through the mechanism of a three-way contract between CMS, the State Medicaid agency and the plan. A successful example of this is the MMP contract management team consisting of all three parties that engages in regular calls and other communication between federal and state regulators and the plan, providing greater administrative flexibility, and ensuring proper alignment of incentives to achieve the best outcomes.
<u>Lack of Adequate Communication</u>	<u>Communication on Integration</u>
Many states that seek to enroll dual-eligible enrollees in an aligned D-SNP or other integrated plans fail to effectively convey the value of an integrated plan to enrollees, medical and community services providers, and the enrollee advocate and stakeholder community. Many also fail to respond	The Association recommends that CMS provide more direction and more resources for states that are progressing to higher levels of integration or enrolling a greater proportion of the dual beneficiary population in integrated plans. These steps should include a more extensive and sustained communication and

adequately to concerns that consumers and advocates raise about the continuity of care and quality of services. As a result, a large number of Medicaid enrollees who could benefit substantially from an integrated plan do not enroll or opt out when passively enrolled, sometimes as a result of provider or stakeholder prompting.	education program with beneficiaries, caregivers, and medical and community service providers, and should start well in advance of implementing any changes to beneficiaries' eligibility, enrollment, or benefits. The Association further recommends that CMS fund video, print, and other materials that effectively communicate to dual beneficiaries with complex care needs, their families, providers, and advocates the value of integration and the advantages in plan operations, benefits, beneficiary experience, and outcomes of enrollment in fully-integrated plans. In addition, the Association recommends that CMS develop an initiative to design and test a variety of incentives that attract providers to engage with and participate in integrated plans.

B. Medicare and Medicaid Alignment

Difficulty Aligning Enrollees in Separate D-SNP & MLTSS Plans	Encourage Alignment for Dual-Eligible Beneficiaries
In states that have D-SNPs and MLTSS plans, beneficiaries may end up in Medicare fee-for-service or in an MA plan that is operated by a different organization than the organization that operates the MLTSS plan to which the beneficiary is assigned by the state. Dual beneficiaries whose Medicare and Medicaid coverage is provided by two different organizations, and is therefore not aligned, will not benefit from the enhanced communication among providers and care coordination the can be achieved in a plan that integrates Medicare and Medicaid services. Aligning Medicare and Medicaid coverage is difficult because Medicare beneficiaries have a choice of traditional (fee-for-	The Association recommends that CMS encourage states to move toward integrated models that provide for enrollment in a single integrated plan (e.g., MMP, FIDE-SNP, and PACE). These fully-integrated models avoid the problems with aligning D-SNP and MLTSS coverage. CMS should help states that do not offer fully-integrated plans for dual eligible individuals advance along the path toward integration. CMS should increase funding for technical assistance that can help states interested in advancing toward full integration and better equip their staff to regulate integrated models through resources like the Integrated Care Resource Center (ICRC).

service) Medicare or any available Medicare Advantage (MA) plan and can enroll in any type of Medicare coverage they choose. It is compounded by the ability of dual eligible Medicare beneficiaries to dis-enroll and enroll on a monthly basis ("churn"). Even when a beneficiary starts out with aligned Medicare and Medicaid coverage, it is it difficult to keep that beneficiary in the aligned coverage. CMS limited the special enrollment period (SEP) for individuals with dual eligibility to one change in their MA plan per calendar quarter, effective January 1, 2019. This provision will help reduce the churn that occurs in MA plan enrollment and reduce some of the factors complicating alignment. Some states that have implemented integrated plans still allow MA plans that do not meet CMS standards for integration to market to and enroll dual eligible individuals in areas already served by integrated D-SNPs (HIDE-SNPs or FIDE-SNPs) and/or Medicare-Medicaid plans (MMPs). In some instances, such plans mislead consumers by employing benefit designs and marketing tactics that misrepresent their offerings as D-SNP plans and/or as being targeted to dual eligible beneficiaries. Such practices could have an adverse impact on integration given that these competing non-integrated MA plans do not meet D-SNP requirements for assessments, care plans, or having a CMS-approved model of care, or for coordinating with Medicaid benefits, either through an aligned Medicaid plan or a contract with a state Medicaid agency. As such, these MA plans employ misleading practices to look like D-SNPs and draw enrollees away from the integrated plans that would better serve their full range of dual eligibles' medical, behavioral health, and LTSS needs.	CMS should also fund more extensive outreach efforts to help dual eligible individuals understand all of the options available to them, with a special emphasis on advantages of enrolling in and remaining in aligned options. State Health Insurance Assistance Programs (SHIPs) and Aging and Disability Resource Centers (ADRCs) should be additionally funded and provided training to inform dual beneficiaries on integrated plan enrollment options. CMS should notify dual eligible individuals who dis-enroll from a D-SNP plan that has an aligned MLTSS plan of the consequences of this change for their coverage and care coordination, and inform them of alternative plan options that would meet CMS integration standards. States that do not offer fully-integrated plans (MMPs or FIDE-SNPs) should be encouraged to require that organizations with Medicaid managed care contracts for aged, blind and disabled beneficiaries and/or for MLTSS offer a D-SNP for their dual beneficiary enrollees that meets CMS's integration standards. For dual eligible individuals moving from an aligned D-SNP to another D-SNP, states should be able to initiate a change in their Medicaid enrollment to align their Medicare and Medicaid coverage and ensure the highest degree of integration possible. CMS and states should enforce and tighten further existing restrictions on the ability of MA-only plans that do not meet D-SNP requirements including CMS integration standards (so called "look-alike" plans) to market to dual eligible

In many states, insurance brokers have played a role in directing dual beneficiaries to MA plans that provide better commissions than the integrated plans are allowed to. CMS has issued marketing and communication guidelines and, recently, additional draft guidelines restricting non-D-SNP marketing activities and communications aimed at dual eligible beneficiaries.	individuals. These plans should be prevented from using benefit designs and/or marketing tactics that violate CMS guidelines on targeting duals, and subsequently, prohibited from enrolling duals. These restrictions would not apply to MA plans in areas where D-SNPs and integrated plans were not available to dual-eligible beneficiaries. The Association also recommends that CMS work with states to explore ways to eliminate the differential in broker commissions and any other incentives that may encourage brokers to direct dual eligible beneficiaries away from enrolling in integrated plans. CMS should consider other ways to encourage dual eligible beneficiaries to enroll in aligned Medicare and Medicaid plans and to avoid changing their Medicare enrollment to fee-for-service Medicare or to an MA plan not meeting CMS integration standards.

C. Enrollment in Integrated Plans

Voluntary MA enrollment complicates efforts to integrate coverage	Provide states more tools to increase integrated plan enrollment
Where integrated options exist, beneficiaries currently are free to enroll in non-integrated coverage. MA enrollment is voluntary and the ability to restrict choice of MA plan is limited – which limits the ability to enroll individuals with dual eligibility in an integrated plan. States have the authority to require that individuals with dual eligibility join an integrated, managed *Medicaid* product; however, section 1851(1) of the Social Security Act prevents	The Association appreciates the importance of the principal of beneficiary choice in the Medicare program. The Association recommends that CMS continue to encourage and incentivize states to move toward integrated or aligned options. In the transition to full integration, dual beneficiaries should retain choice of Medicare coverage. The Association notes that states can require Medicaid

states from requiring that duals join the *aligned Medicare* product offered by the *same managed Medicaid plan*. Medicare beneficiaries, under this section of the Act, are "entitled to elect to receive benefits … through the original Medicare fee-for-service program … or through enrollment in a Medicare+Choice plan." This means that a dual enrolled in a managed, integrated Medicaid plan can (and often will) choose to obtain their Medicare coverage through traditional (fee-for-service) Medicare or through an MA plan offered by a different managed care organization. In states with voluntary enrollment in integrated plans and other Medicare options available for dual beneficiaries, enrollment in integrated plans has rarely exceeded a third of the dual eligible population.[9] CMS allowed MMPs to use passive enrollment with an opt-out. While in a few states the MMPs recruited and retained a high percentage of dual eligible individuals, most states experienced high opt-out rates after individuals were passively enrolled. Surveys of duals dis-enrolling from MMPs found that advice from the individual's physician or their LTSS provider played a significant role in influencing the individual decisions to opt out of integrated plans. CMS discontinued in 2016 the authorization for MA plans to make a "seamless conversion" to a D-SNP for dual eligible beneficiaries enrolled in an MLTSS plan. In its Medicare Parts C & D Final Rule for 2019, CMS re-instituted seamless coverage in the following more limited circumstances:	beneficiaries to receive their coverage through an MLTSS or other managed care plan and enroll them in one of the available plans. Where Medicare and Medicaid coverage are provided through a single plan (e.g., an MMP or FIDE-SNP) some states allow dual beneficiaries to choose whether or not to enroll in the integrated plan, while others passively enroll beneficiaries in one of the integrated plans and allow them the choice to opt-out and enroll in some other arrangement for Medicare. The Association recommends that CMS make passive enrollment to integrated plans available for any state that has highly- or fully-integrated plans. CMS recently made default enrollment and passive enrollment available to states only in limited circumstances, such as when dual beneficiaries enrolled in Medicaid first become eligible for Medicare. If enrollment in integrated plans results in better coordination of coverage and services, then states should not be limited from applying these enrollment strategies for all dual eligible beneficiaries where these plan options are available. Dual beneficiaries passively enrolled in a highly- or fully-integrated plan should be able to opt-out of the plan they are enrolled in and choose to enroll in another plan that meets CMS integration standards. Individuals enrolled in an integrated plan should remain enrolled in that plan until the next open enrollment period, with continuous coverage of existing providers during this

[9] Grabowski, D. C., Joyce, N. R., McGuire, T. G., & Frank, R. G. (2017). Passive Enrollment Of Dual-Eligible Beneficiaries Into Medicare And Medicaid Managed Care Has Not Met Expectations. *Health affairs (Project Hope)*, *36*(5), 846-854.

• Default enrollment – dually eligible beneficiaries in an MLTSS plan, when they become Medicare eligible (due to age or disability), can be enrolled default in an affiliated D-SNP. Individuals can still opt-out to traditional Medicare or an unaligned MA plan. • Passive enrollment – for enrollees already in an integrated D-SNP, CMS can passively enroll a full-benefit-dual individual from a no-longer available D-SNP to a "highly-integrated D-SNP" if coverage would otherwise be disrupted. Passive enrollment to a fully-integrated MMP – with beneficiary opt-out – is also permitted. In many states with highly- or fully-integrated options available, D-SNPs without aligned MLTSS plans continue to enroll dual beneficiaries in areas with integrated options available. Many states require bidders for MLTSS contracts to have a fully functioning D-SNP, which requires companies to "stand up" a D-SNP (enrolling beneficiaries) in anticipation of a state procurement or re-procurement. In order to be prepared to compete for state contracts, organizations need to operate non-aligned D-SNPs in competition with integrated plans.	period. Individuals should have the right to 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. Enrollees should be able to switch to another plan that meets CMS integration standards in the annual open enrollment period. States that do not offer MLTSS or integrated plan options should be incentivized to develop an integrated option and encourage enrollment of all dual beneficiaries in a D-SNP that meets CMS's standards for integration. CMS should work with and provide resources to all states to help them make improvements in the approach they now have that can help them move toward more-integrated models. 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 should also provide an adequate "ramp-up" and "ramp-down" time around MLTSS re-procurement to enable competing organizations to "stand-up" a D-SNP and develop an integrated option and to allow members time after procurement to transition to integrated options. The Association further recommends that CMS provide separate authority in relation to dual beneficiaries through MMCO for "off-cycle" launches of D-SNPs to enable accelerated creation of a HIDE-SNP or other integrated plan to respond to state procurements. Off-cycle approval and launches should be similar to the abbreviated process for approving PACE programs.

D. Plan Payment and Shared Savings with States

Disincentives for States and Plans	Improve State Incentives
Under current state and federal payment approaches for integrated plans, states bear the cost in Medicaid for home- and community-based services while the federal government captures the savings in Medicare from resulting reductions in medical services utilization. The current approach in MMP FFS models for setting rates is the only approach that effectively allows states to share in some of the Medicare savings. A more substantial and consistent approach to share savings across integrated plan types would encourage more States to adopt integrated plans as a way to reduce their overall Medicaid spending. States have suggested, though, that the lack of staff with Medicare expertise and the greater administrative burden associated with integrating with Medicare and/or participating in the three-way contract have been disincentives for states to participate in the Financial Alignment Initiative and launch MMPs, or to consider implementing other highly- or fully-integrated models.	The Association recommends that CMS revise current rate-setting approaches for all models of integrated plans to enable states to share a substantial proportion of Medicare savings generated by the operation of the integrated plan. The revised shared savings approach for integrated plans should be modeled on the federal-state coordinated approach used for FFS MMP models. The opportunity for states that adopt integrated models to apply a greater share of federal savings from Medicare to offset increases in their LTSS spending (resulting from better serving this population) will make the shift to integrated models far more attractive to states. In particular, it will reduce the financial disincentive states may have in adopting integrated models that direct more resources to Medicaid-covered home- and community-based care and away from Medicare-covered medical utilization. The Association further recommends that the Congress consider increasing the federal matching assistance percentage (FMAP) for the Medicaid share of fully integrated plans to offset the higher state administrative burden associated with MMPs and other integrated models and to encourage more states to adopt fully-integrated models. This approach should include providing a 100 percent FMAP to fund a position in each state Medicaid agency for an expert on Medicare to work with integrated plans.

Rate Setting	Uniform Rate-Setting
Most of the integrated plan models require that the plans go through separate rate setting processes (the annual MA bid process and a State Medicaid rate-setting process) that requires separation of Medicare and Medicaid encounters and results in two separate federal and state payment amounts. These separate rate-setting exercises perpetuate the separation of many critical functions within the integrated plan, and complicate the effort to achieve a more integrated experience for the member. The rate-setting processes vary substantially for different types of integrated plans. Medicare rates for integrated plans that include a D-SNP (FIDE-SNP, HIDE-SNP, or aligned D-SNP and MLTSS) are determined through the MA bid process. Medicaid rates for these plans are set independently by the state agency and the rate-setting process varies by state. Medicare and Medicaid rates for MMPs are set jointly by CMS and the state agency. The MMPs' Medicare rates generally reflect the rates that would apply if enrollees were in their previous coverage (Fee-for-Service or MA plan). The Medicaid rates are determined by each state. Rates are then adjusted to share savings between CMS and the state. The PACE process combines separate Medicare and Medicaid payments. Both sets of PACE payments reflect costs in a reference category (for Medicaid it is MLTSS or fee-for-service). Neither of these models require an MA bid submission. Both models have features that promote financial integration and are not subject to the MA bid process. The lack of a uniform payment model for all types of integrated plans creates financial incentives favoring particular models	The Association recommends that CMS adopt a uniform approach to rate-setting for integrated plans. The approach should build from the MMP and PACE models for coordinating federal and state payments.

that lead to unintended results in the types of plans that are offered. Payment for the same person with the same level of medical and functional need should not vary substantially by the type of integrated model the person is enrolled in. <u>Rate Structure</u> States vary considerably in how they determine and structure payment to managed care plans for Medicaid services. Some states structure their MLTSS payment to encourage specific policy results – often separating rates for members in institutional and non-institutional settings and for Dual and non-Dual members. Some states, for example, facilitate transitions for LTSS recipients to more integrated settings by enabling some of the higher institutional rate (that includes the cost of housing) to carry over for members who are transitioning to less expensive settings (where rates do not cover housing) to provide some transitional housing support. State rate-setting approaches for integrated plans should provide incentives for plans to align with state goals for the LTSS population, particularly promotion of home and community-based care, rebalancing, and community integration.	
<u>Inadequate Risk Adjustment</u>	<u>Improved Risk Adjustment</u>
Beneficiaries with significant functional limitations comprise a large part of the total dual-eligible population and are a major contributor to overall health care costs. There is a "frailty adjuster" for Medicare payments to PACE and FIDE-SNP plans that can offset some of this greater cost in plans that enroll disproportionate numbers of members with high functional acuity. This adjustment is not available to other types of integrated plans. In addition, this measure is limited by	Improved risk adjustment would reduce the risk and improve the rewards for plans that specialize in attracting and serving a high-acuity, complex-care population. The Association recommends that CMS/MMCO and CMMI invest in the development of an improved risk adjuster that more fully accounts for the functional limitations and social risk factors of plan members. These factors play a significant

limitations in the survey data (Health Outcomes Survey (HOS)) that is used to create the adjuster. Without an adjustment that fully accounts for the role that functional limitations play in health care costs, plan payments will understate the actual costs of a complex care population and will disadvantage plans that attract and serve enrollees with the greatest LTSS needs.	role in driving health care costs. An improved risk adjuster methodology could be developed and tested using functional assessment data that MLTSS plans have on enrollees for care planning and care management purposes. The resulting adjuster could be applied in integrated plans that provide Medicare benefits for the same membership. Application of the methodology to Medicare D-SNPs that are not integrated would require the administration of a standardized core assessment instrument for dual eligible beneficiaries in those plans. Allowable codes recognizing social risk factors would enable plans to capture and report this data through encounter submissions. Without an overall increase in plan premiums, an increase in the risk adjustment for plans with high concentrations of complex care enrollees would reduce net premiums for plans that have unusually low concentrations of high cost enrollees.

E. Flexibility and Accountability

Insufficient flexibility of benefits	Flexibility of Benefits
Although integrated plans combine resources from Medicare and Medicaid, they are still limited in providing holistic care by the separate benefit definitions and limitations in each program, with the exception of the PACE program. Unlike other integrated plans, PACE organizations can provide members the medical or social supports they need, whether covered under Medicaid or Medicare or not. The	The Association recommends that all integrated plans be given the flexibility that the PACE program has 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

organizations hold the financial risk for all services and supports provided to members, and thus have an incentive to provide those services most likely to achieve the person-centered goals of the member. Other types of integrated plans can, with limited exceptions, provide only benefits explicitly covered by Medicare or Medicaid, even if benefits that are not covered would have a significant effect on the member's outcome.	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.
<u>Disaggregated reporting</u>	<u>Reporting for integrated care plans</u>
Integrated plans, with the exception of PACE plans, are required by Medicare and Medicaid to separately report encounter data, detailing the covered services provided under each program. While PACE has not been required to report specific claims or encounter data in the past, there is a growing movement among states to get PACE organizations to maintain claims data and begin reporting encounters. The disaggregation of services and supports provided to integrated plan members into specific units of service covered by specific program operates against the effort in integrated plans to approach medical and social needs holistically and be accountable for achieving person-centered goals and outcomes developed in the care plans.	The Association recommends that, in addition to the flexibility to provide needed benefits beyond those covered in Medicare or Medicaid, integrated plans should be held accountable for providing services and supports in pursuit of the goals defined in a person-centered assessment and care plan. Under this approach, integrated plans would be able to report progress toward achieving elements of the care plan and person-centered goals, and not be required to disaggregate discrete units of Medicare and Medicaid services and supports that were provided holistically.
<u>Quality measurement focused on input measures</u>	<u>Quality Measurement focused on outcomes</u>
The ability to shift the focus of accountability from input measures (units of service) to outcomes measures (health status, experience of care, goal attainment, quality of life) is dependent on the successful design and implementation of outcome measures for home- and community-based services (HCBS). Only one composite HCBS measure has been	The Association recommends that integrated plans be accountable for not only a members' health outcomes, but also for the members' quality of life and satisfaction, particularly with regard to receipt of non-medical services and supports, including home- and community-based LTSS, provided by the plan.

endorsed to date by the National Quality Forum (NQF), and only a small number of additional HCBS measures are in the process of being validated leading up to NQF endorsement. For the Medicare part of integrated plans, 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. A Medicaid quality reporting system (QRS) is under development, but currently contains very few measures relevant to LTSS and home and community-based services.	The Association supports efforts by CMS, NCQA, NQF, and a number of states to develop and validate measures of quality that relate directly to the attainment of policy goals like rebalancing and integration and capture the experience of care, quality of life, and goal attainment of integrated plan members. The Association recommends that greater effort and financial support go toward implementing a core set of LTSS (particularly HCBS) quality measures, and that plans collaborate with CMS and ACL to begin collecting several HCBS measures that have been or are in the process of being validated and endorsed by NQF. In particular, the Association recommends that Congress revisit the exclusion of LTSS information needs from the HITECH Act of 2009, and provide funding to develop the information infrastructure in the LTSS system needed to improve interoperability of medical and LTSS information needed to coordinate care and improve outcomes for individuals with complex care needs. With regard to Medicare's STAR Rating system, the Association recommends that: • CMS 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; and • Integrated plans not be rated and rewarded solely on the basis of the medical STAR Ratings but also be measured on non-medical and qualitative issues, such as member quality of life and satisfaction, that are relevant to members receiving LTSS.

A Larger Proportion of Dual-Eligible Individuals Enrolled in Integrated Care

A. Expanding State Adoption of Medicaid Managed LTSS

Lack of states with managed LTSS	Increase incentives for state adoption of managed LTSS
Nearly half of the states still provide only traditional Medicaid "fee-for-service" (FFS) coverage with HCBS waivers for older and younger adults with disabilities. A few states have unique state-run systems for managing LTSS. Half (25) of the states have MLTSS or integrated health plans (MMP or FIDE-SNP) covering all or a large part of the state.[10] In Medicaid FFS states, dually-eligible beneficiaries are largely left by themselves to negotiate the confusing array of Medicare and Medicaid coverage rules, with no mechanism for medical and non-medical providers to communicate effectively and coordinate care. Managed LTSS, whether through managed care plans or other state approaches, provides a starting point for aligning Medicaid with Medicare D-SNPs and integrating coverage and care delivery for beneficiaries.	The Association recommends that CMS develop and recommend to the Congress more effective incentives to encourage current Medicaid FFS states to adopt Medicaid managed LTSS as a step toward integration, and ultimately to adopt full integration of Medicare and Medicaid for dual beneficiaries. The Association recommends that CMS consider providing financial incentives through the Federal Medical Assistance Percentage (FMAP) for states to move to managed LTSS and more integrated models of coverage and services. The Association also recommends providing a greater amount of shared Medicare savings with the states through integrated models to encourage movement toward integrated options.

B. Advancing Integrated Models as the Preferred Form of Coverage for Duals

Low rates of participation in integrated plans	Incentivize enrollment of "duals" in integrated plans and phase-out other options
In most states that have made integrated plans available, participation rates by dual beneficiaries in these plans remain low. In some states where enrollment in the integrated plans	The Association recommends that Congress fund more aggressive efforts to develop the evidence needed to demonstrate the value of integration for duals; and to

[10] NASUAD (2018). State Medicaid Integration Tracker: December 21, 2018. Available from: http://www.nasuad.org/sites/nasuad/files/December_2018_State%20Medicaid%20Integration%20Tracker_FINAL%202.pdf

has been voluntary, a large percentage of dual eligibles do not enroll in them – whether as a matter of choice, lack of information, or loyalty to their providers. Often duals have little information or understanding of the added value for them of enrollment in an integrated plan. Evidence of the lower costs and better outcomes achieved by integrated plans is, to date, limited.[11] In states with integrated approaches that include passive enrollment that allows beneficiaries to opt-out of the plan, opt-out rates have been high – often due to efforts by medical, LTSS providers, to discourage enrollment, or to insurance brokers marketing to "duals" for enrollment in non-integrated plans.[12] While some states have moved to prevent unaligned D-SNPs or other MA plans from operating in a county or state where FIDE-SNPs or MMPs are available, most states still allow unaligned D-SNPs and other MA plans to market to dual beneficiaries. CMS has issued rules defining a pathway that states can follow in moving toward highly- and fully-integrated models. States should be incentivized to pursue these models.	communicate, through a public education effort, with assistance from states, integrated plans, and consumer advocates, the advantages for duals of integrated approaches compared to continuing in a disconnected, un-integrated, FFS environment. CMS should also consider ways to engage physicians in supporting more integrated models for their dual beneficiary patients, including the possibility of structuring financial incentives for physicians who serve dual beneficiaries to participate in integrated models. The Association also recommends that CMS and the Congress continue to improve the financial and other incentives available for states that adopt fully-integrated models (MMP, FIDE-SNP, PACE). CMS and/or the Congress should adopt a plan to encourage and incentivize States to move up the ladder of toward full integration. The plan would specify ways for States to move toward integration, while taking into account the ability for members to maintain choices in what plans they enroll in. It would also address the creation of a new approach for partial duals, and would propose ways to tighten integration/coordination requirements for D-SNPs and state agencies in states without managed LTSS.

[11] MEDPAC (2018). *Report to the Congress: Medicare and the Health Care Delivery System. Chapter 9: Managed care plans for dual-eligible beneficiaries.* Available from: http://www.medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0

[12] Walsh, E. et al. (2018) *Financial Alignment Initiative California Cal MediConnect: First Evaluation Report*. RTI International. Retrieved from: https://innovation.cms.gov/Files/reports/fai-ca-firstevalrpt.pdf

C. Reporting Annually on Progress Toward Full Integration

Lack of specific accountability for progress on duals' integration	Adoption of a target and annual reporting on progress
There are few easily accessible statistics on the proportion of dual eligible beneficiaries enrolled in various kinds of health plans by state and sub-state area. As a result, it is difficult to track change over time or see evidence of progress toward full integration.	The Association recommends that CMS contract with an outside party to compile and disseminate an Annual Report on progress toward full integration for Duals. The Annual Report would: • Include five- and ten-year targets for coverage of the population of dual beneficiaries in integrated plans. • Chronicle federal legislative and regulatory changes that contribute to advancing integration, and state legislative and regulatory changes that increase adoption of and enrollment in integrated plans. • Include an annual compilation of statistics on enrollment by state under various arrangements. It would also report quality metrics – outcomes, satisfaction, quality of care – by state and plan within state. • Recommend legislative and regulatory changes to improve the model, improve the beneficiary experience, and accelerate movement toward integrated models.