National
MLTSS
Health Plan Association

The National MLTSS Health Plan Association's Policy Proposals to Advance Integrated Care

The National MLTSS Health Plan Association has supported Congress to educate policymakers on the needs, programs, and opportunities to better serve individuals dually-eligible for Medicare and Medicaid. In response to those interactions, in Fall of 2020, Association members approved a series of strawman policy proposals to put forward to relevant Committee staff for their consideration as they develop legislative solutions for better integrated care. Throughout 2021, the Association's Integrated Care Policy Proposals Work Group has worked collaboratively to add more detail to each proposal and to reach consensus. The proposals fall under five priority areas:

Priority Area	Problem Description
1) Advance State Capacity to Operate Integrated Care Products	One factor that contributes to a lack of state adoption of integrated care products (e.g., Medicare-Medicaid Plans (MMPs)) is their administrative complexity. This complexity is further exacerbated by limited staff expertise of the Medicare program within applicable State agencies.
2) Streamline Enrollment Processes for Integrated Care Products to Create a Seamless Experience and Reduce Consumer Burden	At a national level, less than ten percent of all dually-eligible beneficiaries are enrolled in an integrated product. Ultimately, beneficiaries must be enrolled in integrated products for the benefits of integration to be realized. Current enrollment processes result in beneficiary confusion and fragmentation as beneficiaries must navigate two separate programs and enrollment processes.
3) Create an Even Playing Field for Integrated Care Products and Simplify Their Administration	Various integrated products are regulated under different statutory authorities and contain variations in basic programmatic features such as payment, enrollment, and marketing. These differences lead to unintended incentives for states, plans, and providers to operate one over the other despite serving the same general population.
4) Improve Medicare Data Access for MLTSS Plans to Support Care Coordination for their Dually-Eligible Members	While MLTSS plans and providers gain valuable insights into dual-eligibles' health care needs and quality of life through LTSS interventions, fundamental system constraints limit their access to primary care provider (PCP) and other medical utilization data. Improving MLTSS plans' access to Medicare data will allow them to better respond to and coordinate their medical and non-medical needs. An initial step is providing plans with the Medicare program in which their dually-eligible members are enrolled.
5) Increase Stakeholder Awareness of the Benefits of Integration	Multiple stakeholders have identified that a consistent issue with standing up integrated care products and further maintaining enrollment is a lack of beneficiary and provider understanding. This was a notable issue in the initial phases of certain MMP programs. Beneficiaries may be faced with the possibility of selecting from an MMP, PACE program, D-SNP, traditional MA, or traditional FFS in certain markets yet there is currently no consistent source of information that enables them to weigh their options.

The proposals include the following:

1. Create a new special enrollment period for beneficiaries to enroll into an integrated care product on a continuous (monthly) basis;
2. Develop a database with Medicare data for all dually-eligible beneficiaries that MLTSS plans can access for their members;
3. Add standard elements to 834 Benefit Enrollment and Maintenance Files across states to facilitate coordination for dually-eligible beneficiaries.
4. Expand the current scope of default enrollment;
5. Provide MMCO with funding to establish a grant program for states to build their capacity to design/implement integrated care programs;
6. Uniformly apply the frailty adjuster to all highly integrated products;
7. Develop national and state-level tools for beneficiaries and other stakeholders to help beneficiaries navigate the integrated care market;
8. Update Medicare Plan Finder to include new functionality and information on integrated care products;
9. Expand MMCO's authority over integrated care products;
10. Expand the current scope of passive enrollment; and
11. Provide states with an FMAP increase to operate/improve integrated care programs.

Below we offer additional details and technical comments on each of these proposals.

1) Create a new special enrollment period for beneficiaries to enroll into an integrated care product on a continuous (monthly) basis

Priority Area	Streamline enrollment processes for integrated care products to create a more seamless experience and reduce consumer burden
General Description	Create a new special enrollment period (SEP) for dually eligible beneficiaries to enroll into a D-SNP or MMP
Specific Mechanism of Change	Allow dually eligible beneficiaries in Original Medicare to enroll into a managed care product (i.e., D-SNP or MMP) on a continuous (monthly) basis. Once enrolled, beneficiaries cannot switch between D-SNP/MMP products outside of existing enrollment timelines. This is not intended to change existing enrollment timelines for those already enrolled.
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	Limiting the SEP to new enrollments in integrated care products helps to increase beneficiary choice and facilitate better and more consistent care management.

2) Develop a database with Medicare data for all dually-eligible beneficiaries that MLTSS plans can access for their members

Priority Area	Improve Medicare data access for MLTSS plans to support care coordination for their dually-eligible members
General Description	Require CMS to establish a database with Medicare data for all dually-eligible beneficiaries that MLTSS plans would have access to for their members
Specific Mechanism of Change	CMS would be responsible for establishing a database with Medicare data for all dually-eligible beneficiaries. The database would include the beneficiaries' Medicare program enrollment and Medicare contract number (if applicable), and potentially their Medicare claims data in the future.
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	MLTSS plans can only download data for their members for whom they can verify enrollment in their plan using key identifiers (e.g., plan has a beneficiary's date of birth and Social Security Number or Medicare Beneficiary Identifier).

3) Add standard elements to 834 Benefit Enrollment and Maintenance Files across states to facilitate coordination for dually-eligible beneficiaries

Priority Area	Improve Medicare data access for MLTSS plans to support care coordination for their dually-eligible members
General Description	Require states to add standard elements to their 834 Benefit Enrollment and Maintenance Files
Specific Mechanism of Change	States would be required to add standard elements (e.g., Medicare program enrollment, Medicare contract number) to their 834 Benefit Enrollment and Maintenance Files that will enhance MLTSS plans' information on their dually-eligible members and support better care coordination.
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	This information would only be available for MLTSS plans' members.

4) Expand the current scope of default enrollment

Priority Area	Streamline enrollment processes for integrated care products to create a more seamless experience and reduce consumer burden
General Description	Expand default enrollment authority beyond newly eligible beneficiaries to all dually eligible beneficiaries in Original Medicare enrolled in the parent company's managed care organization with an option to opt-out; this should not disrupt or replace the current default enrollment authority.

Specific Mechanism of Change	HIDE-SNPs and FIDE-SNPs which meet current requirements for performance indicators (i.e., 3 star rating and above, or no star rating if the plan is new/has low enrollment) would be eligible to default enroll dual-eligible beneficiaries into the HIDE-SNP or FIDE-SNP if the beneficiary is enrolled in Original Medicare and in the HIDE/FIDE's parent company's Medicaid managed care organization. Moreover, the expanded authority would apply to any HIDE-SNP and FIDE-SNP entities that have a Medicaid contract which covers, at minimum, a comprehensive set of long-term services and supports as well as home and community-based services with reasonable state-specified service exclusions and carve-outs.
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	• HIDE-SNPs/FIDE-SNPs need to notify beneficiaries 60 days prior to effective enrollment date and follow continuity of care provisions for 6 months. • Performance indicators that plans have to meet to be eligible for default enrollment should be set at a 3 star rating. • Consumer protection floor should follow MMP guidelines. • Beneficiaries have 60-90 days to opt out. • If a beneficiary has actively chosen a product (i.e. standalone D-SNP, HIDE, FIDE, MMP), they should not be moved to another option through default enrollment to preserve beneficiary choice.

5) Provide MMCO with funding to establish a grant program for states to build their capacity to design/implement integrated care programs

Priority Area	Advance state capacity to operate integrated care products
General Description	Provide funding for MMCO to create a planning grant program for states pursuing integrated care
Specific Mechanism of Change	MMCO would be responsible for creating a grant program for states who wish to apply for a one-time planning grant to perform a certain set of activities (e.g., hiring new administrative staff with Medicaid and Medicare knowledge; building integrated IT infrastructures to connect with CMS', health plans', and providers' information systems) related to improving integrated care for existing and/or future improvements to integrated care programs. States receiving grant funding would be required to implement a training for state employees on the dually-eligible population and integrated care programs.
Funding Mechanism	Congressional appropriation for a grant. States would apply for funding for budgeted purposes.
Consumer Protections/Guardrails	Not applicable

6) Uniformly apply frailty adjuster to all highly integrated products

Priority Area	Create an even playing field for integrated care products and simplifying their administration
General Description	Apply the frailty adjuster to all highly integrated products
Specific Mechanism of Change	MMP rates and the rates of any future highly integrated products could be adjusted by the applicable rate under current frailty adjuster methodology.
Funding Mechanism	Increased Medicare expenditures for A/B rates
Consumer Protections/Guardrails	Not applicable

7) Develop national and state-level tools for beneficiaries and other stakeholders to help beneficiaries navigate the integrated care market

Priority Area	Increase stakeholder awareness of the benefits of integration
General Description	Require CMS, MMCO, and ACL, in collaboration with other stakeholders, to develop educational materials to be used on the national level on the benefits of integrated care AND provide funding for ACL to develop state-specific resources for counseling for dually-eligible individuals on their options for integrated care products
Specific Mechanism of Change	CMS, MMCO, and ACL, in collaboration with other stakeholders, would be required to develop educational materials to be used on the national level on the benefits of integrated care with the goal of increasing beneficiary, provider, SHIP (and other counseling entities), and MA broker awareness and knowledge of integrated care products. The process of developing materials should include the opportunity for external stakeholder input. In addition, ACL would be responsible for creating a grant program for states who wish to apply for a one-time grant to develop, in partnership with the SHIP TA Center, state-specific training modules for SHIP Counselors and other state-specific educational materials for SHIP Counselors, AAAs, beneficiaries, providers, MA brokers, and other entities providing beneficiary counseling on integrated products in their states. Funding would support staff time spent developing training modules/materials, training and educating relevant entities on integrated care products and managed care in general, facilitating greater coordination between SHIP programs and Medicaid agencies within states, customizing materials by region, etc.
Funding Mechanism	Appropriation from Congress for new grant program under ACL. States would apply for funding for budgeted purposes.
Consumer Protections/Guardrails	The training, materials, and guidance could be required to be impartial to any particular coverage arrangement for a dually-eligible beneficiary.

8) Update Medicare Plan Finder to include information on integrated care products

Priority Area	Increase stakeholder awareness of the benefits of integration
General Description	Require CMS to update Medicare Plan Finder to include new functionality and information on integrated care products
Specific Mechanism of Change	CMS would be required to develop functionality in Medicare Plan Finder to identify integrated plans and the level of integration, and to provide high-level general information on the benefits and advantages of integrated care products.
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	Any proposed updates to the Medicare Plan Finder should be simplified by a health literacy expert and undergo user testing to ensure they are clear and understandable to consumers.

9) Expand MMCO's authority over integrated care products

Priority Area	Create an even playing field for integrated care products and simplifying their administration
General Description	Provide MMCO greater oversight over D-SNPs, MMPs, PACE, and any other future products targeted towards dual-eligible beneficiaries
Specific Mechanism of Change	Authority over all integrated products would be permanently transferred from CMMI to MMCO. MMCO would have greater oversight and ability to make modifications to integrated care programs compared to current limitations in areas such as enrollment, marketing, grievances & appeals, and technical assistance (e.g., regular check-in meetings with MMCO, plans, and states). Any enhanced oversight should seek to simplify administration and streamline regulatory reporting.
Funding Mechanism	Congressional appropriation for a potential increase in budget for MMCO
Consumer Protections/Guardrails	Not applicable

10) Expand the current scope of passive enrollment

Priority Area	Streamline enrollment processes for integrated care products to create a more seamless experience and reduce consumer burden
General Description	Expand CMS's authority to allow passive enrollment of dually eligible beneficiaries in Original Medicare into HIDE-SNPs and FIDE-SNPs with an option to opt-out
Specific Mechanism of Change	CMS would have the authority to passively enroll beneficiaries in Original Medicare into HIDE-SNPs and FIDE-SNPs whose parent companies have a history of meeting current requirements for performance indicators (i.e., 3 star rating and above, or no star rating if the plan is new/has low

	enrollment); this authority would be used to create aligned enrollment (i.e., beneficiary enrollment in the same MCO and MA plan offered by the parent company) in these new products.
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	• HIDE-SNPs/FIDE-SNPs need to notify beneficiaries 60 days prior to effective enrollment date and follow continuity of care provisions for 6 months. • Performance indicators that plans have to meet to be eligible for passive enrollment should be set at a 3 star rating. • Consumer protection floor should follow MMP guidelines. • Beneficiaries have 60-90 days to opt out. • If a beneficiary has actively chosen a product (i.e. standalone D-SNP, HIDE, FIDE, MMP), they should not be moved to another option through passive enrollment to preserve beneficiary choice.

11) Provide states with an FMAP to operate/improve integrated care programs

Priority Area	Advance state capacity to operate integrated care products
General Description	Provide an FMAP increase to states to help offset the ongoing costs of operating integrated care programs to incentivize more state action
Specific Mechanism of Change	States who implement certain kinds of integrated care programs would be eligible to receive an increased FMAP (based on the population of dual-eligible individuals enrolled in the integrated care program) to support operational activities (e.g., facilitating care coordination; supporting ongoing oversight, monitoring, and stakeholder engagement staffing needs).
Funding Mechanism	Congressional appropriation for an FMAP increase. The FMAP increase would apply to the state's administrative expenses and/or non-administrative expenses
Consumer Protections/Guardrails	Not applicable