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## SNP Alliance Issue Brief

### Enrollment Alignment is Essential to Fully Integrated Care For Medicare-Medicaid Beneficiaries

#### **Synopsis**

While much progress has been made to simplify access and improve coordination of services for Medicare-Medicaid beneficiaries through integration of Medicare and Medicaid managed care programs, many beneficiaries are still enrolled in unrelated entities for both programs, further complicating an already fragmented delivery system for this highly vulnerable high needs group. We will not achieve the quality and cost outcomes expected and possible until both Medicare and Medicaid services are coordinated through one plan and enrollment is better aligned between both programs. This brief provides context as to why alignment of enrollment in related Medicare and Medicaid plans is essential to integration efforts and outlines both challenges and best practices for moving forward, understanding that incremental steps are needed to accommodate the wide variations in state interests and resources to address these issues and the differences in market dynamics in which plans must operate.

#### ***Medicare-Medicaid Beneficiaries Face Two Uncoordinated Systems***

Congress and the Centers for Medicare and Medicaid, along with states, consumer advocates and health plans have long been interested in improving care for the nation's 11.7 million people dually eligible for both Medicare and Medicaid (*MMCO Fact Sheet 2/18*) through better integration of service delivery and coordination between program requirements. These "Medicare-Medicaid beneficiaries" have multiple chronic health conditions requiring high levels of long term community supports and services (LTSS) and behavioral health services, and make up over a third of total costs in both programs. On top of their health and LTSS needs, Medicare-Medicaid beneficiaries face a maze of confusing, fragmented, duplicative and often conflicting administrative processes and cost shifting incentives as they try to access needed care through two separate and poorly coordinated programs.

States have increasingly turned to managed care plans to manage Medicaid LTSS costs with 24 states now having some form of Managed LTSS (MLTSS) program. More Medicare-Medicaid beneficiaries are also choosing to enroll in Medicare Advantage (MA), including 2.3 million now enrolled in 190 MA Dual Eligible Special Needs Plans (D-SNPs) under contracts with 41 states. (*CMS SNP Comprehensive Report 7/18*).

#### ***Caught in the Middle: Enrolled in Multiple Unrelated Plans***

An unknown number of Medicare-Medicaid beneficiaries are actually enrolled in two (or possibly three) unrelated plans such as an MA plan plus a freestanding Prescription Drug Plan (PDP), and/or an MA plan with Prescription Drugs (MA-PD) or a D-SNP in addition to a Medicaid MCO under a different plan sponsor. A range of existing enrollment situations are illustrated on the integration continuum below.

Medicare Parts A&B	Original (FFS)	Original (FFS)	MA	MA-PD	SNP	D-SNP	FIDE-SNP	MMP/PACE One Aligned Plan
Medicare Part D	PDP	PDP	PDP					
Medicaid	FFS	Different Medicaid MCO	Different Medicaid MCO	Different Medicaid MCO	Different Medicaid MCO	Aligned MCO (same plan sponsor)	Aligned MCO	
Medicaid MLTSS and/or BH	FFS	FFS	FFS	FFS	FFS or Different MCO	FFS or Different MCO		

When a Medicare-Medicaid beneficiary is enrolled in two or three unrelated plans, they are “caught in the middle” and the result can actually be harmful to the beneficiary. The opportunity for maximizing their care is missed and an already confusing system is made more difficult as they are subject to conflicting and fragmented information from multiple sources as well as potential conflicts between care management strategies and financial incentives including:

- Two or three separate eligibility and enrollment cards (Medicare A&B, Medicare Part D and Medicaid)
- Two or three separate sets of member materials and notifications, containing often conflicting coverage information (Medicare, Part D and Medicaid)
- Two care plans kept in two different places under two care coordination systems by two different care coordinators where neither has a full picture of the beneficiaries’ total needs or service utilization history.
- Navigation of two separate provider networks with potentially significant differences in key provider choices.
- Two places to call for information, neither of which may have access to the full information needed.
- Benefit determinations, utilization management systems, and provider payments that are split between two different parent entities with separate and often conflicting financial incentives.
- Poor incentives between plans and providers, for example:
  - A Medicare plan may determine that a nursing home placement is best in order to reduce hospitalizations and stabilize a member. But Medicare covers only short-term stays. After Medicare coverage stops, a lower-income beneficiary who needs a longer stay then uses up their assets and loses their housing and other community supports that would have enabled them to return home, and ends up stuck in the nursing home. The beneficiary then “spends in” to Medicaid where the Medicaid plan and the state are responsible for the nursing home costs.
  - A nursing home paid under a Medicaid plan may have incentives to send a more complex Medicaid resident to the hospital when a visit from a Medicare paid nurse practitioner who could prescribe an antibiotic might be equally effective and less disruptive to the resident. Even with an available NP, staffing challenges can lead nursing homes to transfer residents with increased care needs to hospitals when more cost effective strategies involving additional coordination across both plans and payers could be employed.

## ***Building Better Links between Medicare and Medicaid***

Recognizing the need for improved coordination of care between Medicare and Medicaid, Congress established the Medicare-Medicaid Coordination Office (MMCO) in 2010. Since then the MMCO has worked with states and plans to implement the Financial Alignment Initiative (FAI) involving ten states with capitated models providing integrated care to about 380,000 enrollees through joint Medicare-Medicaid plans (MMPs), as well as a D-SNP administrative alignment demonstration in Minnesota. (*JCRC 7/18*). The MMCO also provides technical support and information to states interested in working to integrate care through D-SNPs. In 2018, ten states require that their Medicaid managed care plans sponsor corresponding D-SNPs, encouraging enrollment in both plans. 46 D-SNPs now qualify as Fully Integrated Dually Eligible SNPs (FIDE SNPs) providing both Medicare and Medicaid including MLTSS services with enrollment of 177,242 (*CMS 7/18*). In 2018 Congress made D-SNPs a permanent part of the MA program, spelling out expectations and requirements for further integration of Medicare and Medicaid and strengthening the MMCO's role in assisting plans and states with integration efforts.

A growing body of research indicates that ***when Medicare-Medicaid beneficiaries are enrolled in the same plan or parent company sponsor for both Medicare and Medicaid*** there is greater potential to reduce conflicting financial incentives between the two programs, increase access to community-based services, and improve coordination of care, health outcomes and the overall quality of care delivery. <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>  
[http://avalere.com/research/docs/20120627\\_Avalere\\_Mercy\\_Care\\_White\\_Paper.pdf](http://avalere.com/research/docs/20120627_Avalere_Mercy_Care_White_Paper.pdf)  
 (MedPAC RTC June 2018, page 286.)

## ***Status of Medicare-Medicaid Beneficiary Enrollment***

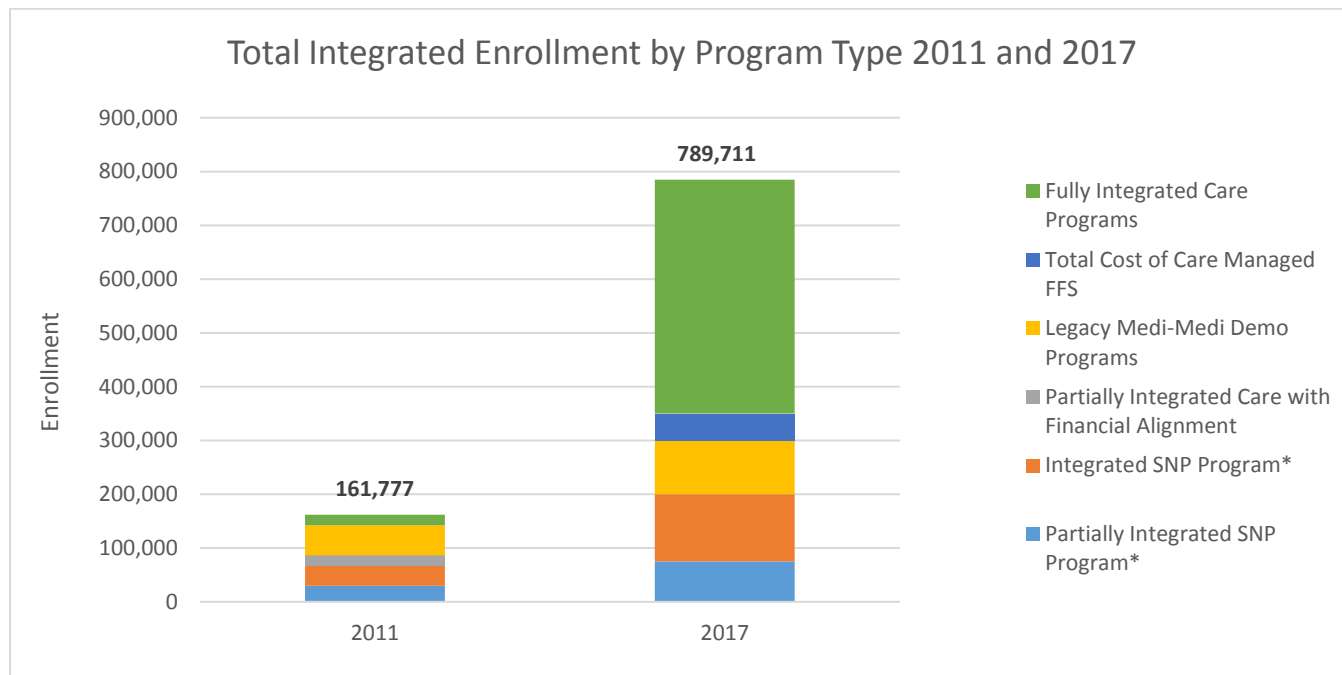
Most Medicare-Medicaid beneficiaries are not enrolled in the same plan for both Medicare and Medicaid. Kaiser estimates indicate that in 2014 up to 32% had chosen to enroll in a Medicare Advantage plan. <https://waysandmeans.house.gov/wp-content/uploads/2017/06/2017.06.07.-HL-Testimony-Jacobson.pdf>. However the majority are enrolled in Medicare fee for service (FFS) plus a Medicare Prescription Drug Plan (PDP).

About 52% of all Medicare-Medicaid beneficiaries receive at least some services through Medicaid FFS. However, a growing number of full benefit dual eligibles (FBDEs) 63%, are enrolled in a Medicaid Managed Care Organization (MCO) for at least a portion of time and/or services. (*MedPAC MACPAC Data Book January 2018*.) As outlined further below, a relatively small proportion of Medicaid-Medicare beneficiaries are enrolled in aligned Medicare Medicaid plans sponsored by the same parent organization.

## ***Status of Enrollment Alignment***

While available data indicates that enrollment in integrated plans has grown significantly from 2 to 8% since 2011 (*June 2018 MedPAC Report to Congress*), outside of FAI MMP enrollments and FIDE SNP enrollment data collected by CMS it is not easy to determine exactly how many Medicare-Medicaid beneficiaries are enrolled in aligned plans. The most specific information on aligned enrollment available comes from the MMCO's 2017 Report to Congress in the chart below which indicates that about 789,711 Medicare-Medicaid beneficiaries are enrolled in fully or partially integrated plans including MMPs, integrated D-SNPs and PACE programs. "Integrated SNP Program" and "Partially Integrated SNP Program" enrollment includes programs in which a Medicare-Medicaid enrollee receives both Medicare and Medicaid services from companion or aligned Medicare D-SNPs and Medicaid managed care plans.

## EXCERPT: MEDICARE-MEDICAID COORDINATION OFFICE FISCAL YEAR 2017 REPORT TO CONGRESS



**Source:** Analysis performed by the Integrated Care Resource Center, under contract with CMS. “Fully Integrated Programs/Models” include MMP and PACE enrollment through July 2017. “Total Cost of Care Managed FFS” includes enrollment in the Colorado and Washington Managed Fee-For-Service demonstrations under the Medicare-Medicaid Financial Alignment Initiative. “Legacy Medi-Medi Demo Programs” includes enrollment in FIDE SNP programs in Massachusetts, Minnesota, and Wisconsin that began as demonstrations. “Partially Integrated Care with Financial Alignment” refers to the North Carolina Medicare Health Care Quality Demonstration; no 2015, 2016, or 2017 information is included because the initiative had ended. “Integrated SNP Program” and “Partially Integrated SNP Program” enrollment includes programs in which a Medicare-Medicaid enrollee receives both Medicare and Medicaid services from companion or aligned Medicare D-SNPs and Medicaid managed care plans.

### **Why is Enrollment Alignment Important to Improved Care for Medicare-Medicaid Beneficiaries?**

State and D-SNP efforts to proceed toward further integration of fragmented care between Medicare and Medicaid are highly dependent on what proportion of their enrollees are enrolled in linked Medicare and Medicaid products. When the same entity is financially responsible for all Medicare and Medicaid benefit policies and operations, the two programs can appear nearly seamless to enrollees and to providers. Financial incentives can be aligned and coordinated value-based payment systems can be facilitated across both programs, allowing Medicaid benefits to complement efforts to reduce hospitalizations and Medicare benefits to complement efforts to reduce long term nursing home stays. Provider payments, including Medicaid-covered cost sharing and value based purchasing initiatives, can be coordinated through one entity, allowing providers to focus on helping enrollees maintain or improve health outcomes across the full range of health conditions and needed services for that individual.

Most critically, aligned enrollment enables more effective care coordination models that can bridge primary, acute and long term services and supports across Medicare and Medicaid. Unlike Original Medicare or typical MA plans, MMPs and D-SNPs are required to develop and follow extensive Medicare Models of Care (MOCs) designed specifically for the needs of Medicare-Medicaid beneficiaries. These MOCs include features such as initial health risk assessments, comprehensive assessments, development of individual plans of care with individualized person centered goals, in home care coordination visits and interdisciplinary teams. Where enrollment is aligned, plans can combine related Medicare MOC and Medicaid MLTSS care coordination functions to meet the full range of enrollee needs and overcome the artificial barriers that normally splits care into separate systems. For example, plans can assign one care coordinator to the enrollee and develop one comprehensive care plan for access to all services. Absent aligned enrollment, members may be faced with multiple care managers and two different care plans, assessment systems and models of care, resulting in conflicting or uncoordinated goals.

Aligned enrollment is also fundamental to achieving the integrated operational features necessary to support a more seamless and efficient system for Medicare-Medicaid beneficiaries. MMPs and some FIDE SNPs and highly integrated D-SNPs have been able to integrate, coordinate or combine Medicare and Medicaid operational features such as: contract communications, enrollment cards and processes, member materials and notices with joint reviews, benefit determinations, marketing strategies, member services and call centers, grievance and appeals processes, quality improvement data and reporting of both Medicare and Medicaid information, value-based provider payment and contracting arrangements and other operational functions.

As indicated by experience with integrated programs in AZ, ID, MN, NJ and TN, to the extent enrollment can be substantially aligned under the same plan sponsor, many of these operational features can be integrated under D-SNPs without additional demonstration authority through negotiated agreements between plans and states. Federally required D-SNP contracts with states under the Medicare Improvements for Patients and Providers Act (MIPPA) can even be combined with state Medicaid contracts to further facilitate integration.

### ***Challenges to Enrollment Alignment***

As states move to managed LTSS systems for Medicaid and require their MCOs to offer Medicare D-SNPs, more Medicare-Medicaid beneficiaries are enrolled in Medicaid MCOs for all Medicaid services with an opportunity to enroll in a corresponding D-SNP. However, depending on a host of difficult-to-control factors states and plans still face significant challenges in achieving enrollment alignment.

### **Differences between Medicaid and Medicare Plan Choice Policies**

Despite the best efforts of states and plans, policy differences in how beneficiaries choose plans can result in their being enrolled in one plan for Medicare, and another for Medicaid.

- **Medicare Choice Policies:** Under Medicare, Medicare-Medicaid beneficiaries have freedom of choice to enroll in Original Medicare with a freestanding PDP, an MA plan with a freestanding PDP, an MA-PD that also includes prescription drugs, or a SNP plan (D-SNP, I-SNP or C-SNP depending on SNP specific enrollment criteria) which also includes prescription drugs. While this freedom of choice does not appear to be based on a specific statutory requirement, it is a long standing CMS policy that consumers have come to expect. However it can also be a significant barrier to alignment of enrollment as explained further below.

- **Medicaid Choice Policies:** Under Medicaid, states have the choice to set up either mandatory or voluntary managed care programs. More states are now including Medicare-Medicaid beneficiaries in mandatory programs. These programs often include auto-enrollment or passive enrollment (with some opt out protections) of most FBDEs into Medicaid MCOs. This passive enrollment may or may not align with their Medicare plan enrollment.
- **Passive Enrollment Differences:** However, under Medicare, MA plan enrollment is not mandatory and use of passive enrollment has been limited mostly to MMPs participating in the FAI demonstrations. While states can assign Medicare-Medicaid beneficiaries to a Medicaid plan, in general they are not allowed to require the beneficiary to enroll in a companion D-SNP. So when plans chosen for Medicaid do not align with existing or potential Medicare plans and the state is planning to passively enroll all Medicare-Medicaid eligible beneficiaries into separate Medicaid MLTSS plans, many beneficiaries may end up in one plan for Medicaid and another for Medicare.
- **Medicare PDP Auto Assignment:** In addition, Medicare-Medicaid beneficiaries who are newly eligible for Medicare and who remain in Original Medicare and have not chosen a PDP are subject to periodic auto-assignment to a freestanding PDP by CMS to assure drug coverage. While there are certain “opt out” protections, under recent changes in Medicare rules reducing the special election periods for all Medicare-Medicaid beneficiaries, these members may be subject to periodic “lock in” to the PDP so may not be able to choose an integrated plan at the most beneficial time.
- **Non-aligned Medicare Plan Choices:** Further, many Medicare-Medicaid beneficiaries have chosen to enroll in MA-PDPs, C-SNPs or I-SNPs to take advantage of supplemental benefits or SNP features designed for their chronic conditions or institutional status. Since MIPPA contracts are not required for these plans, most states do not have contracts with these Medicare plans. If these members are passively enrolled into separate Medicaid plan sponsors, they will also end up in two separate plans.

### **Differences between Contracting and Procurement Approaches and Schedules**

Enrollment alignment or the potential for it varies significantly among states, and is highly dependent on coordination of state Medicaid procurements and timelines with Medicare SNP applications and bid timelines.

- **State Contracting Schedules:** States may have constraints on contracting and procurement dates due to statewide administrative policies, legislative expectations, relationships to much larger managed care contracts for other populations and products, or other operational considerations. Bringing up a matching D-SNP in conjunction with an MLTSS procurement typically takes 18-24 months at minimum, requiring pre-planning that can be challenging for states depending on election cycles and leadership changes.
- **Medicaid Plan Consolidation:** States may also have a desire to reduce or further control the number and types of plans with which they contract for Medicaid or offer MIPPA contracts. Issues include whether existing Medicare plan sponsors such as D-SNPs can qualify or are chosen under state RFP criteria to provide state Medicaid and MLTSS services under state MCO contracts.
- **State MIPPA Contract Policies:** D-SNPs are required to have state Medicaid approval and MIPPA contracts before they can operate, and some state have limited their MIPPA contracts only to those sponsored by existing Medicaid MLTSS MCOs or those that are already serving other Medicaid populations. 6 states won't sign contracts unless that plan is also an MLTSS plan. (MedPAC RTC June 2018). Others are curtailing approval of MIPPA contracting in service areas where MMPs are operating.

- **Other Medicare Plans:** However, non-D-SNP MA plans are not subject to the requirement for state approval and some have designed other types of MA plans to attract Medicare-Medicaid beneficiaries. Unlike D-SNPs, these MA plans are not required to have specialized Models of Care tailored to Medicare-Medicaid beneficiaries. Some of these plans are invested in providing care coordination attractive to and designed for the needs of Medicare-Medicaid beneficiaries, while others do not offer such specialized care, further complicating options for enrollment alignment and integrated service delivery. In addition, financial incentives imbedded in broker sales of such plans may exacerbate misalignment with state Medicaid and MLTSS plan enrollment.

### **Mismatched Enrollment Parameters**

Enrollment parameters established by the state or previously chosen by the plan also impact the ability to align enrollment. CMS allows states to determine enrollment parameters for the dually eligible “subset” that is eligible to enroll in a D-SNP and this must be specified in the MIPPA contract. (Explanations of allowed subsets are found in MMCM Chapter 16b, 20.2.2. and Chapter 2, 20.11). Key factors include:

- **Existing vs New Dual Subsets:** The extent to which D-SNPs are already serving many existing members (such as “partial duals”) who are not eligible to enroll in the Medicaid plan, how any mismatches in enrollment parameters impact the ability to align enrollment and integrate operational features, and whether the state decides it can exercise its ability to require that existing and/or new D-SNPs serve a “dual subset” that matches the Medicaid managed care enrollment.
- **Differences Between Medicaid and MIPPA Enrollment Parameters:** Most states restrict Medicaid managed care enrollment to full benefit dual eligibles (FBDEs). However, some states and plans have MIPPA agreements that allow D-SNPs to enroll populations (usually partial duals and/or other carved out groups) that are not included in the Medicaid managed care program to enroll in D-SNPs. Enrollment of populations whose Medicaid benefits are quite different from those of FBDEs into the same D-SNP poses additional challenges to enrollment alignment, and further complicates integration of member materials and care coordination models as outlined below.
  - **Partial Duals:** While non-FBDEs can benefit greatly from the additional care coordination and supplemental benefits tailored to dual eligibles in D-SNPs, these “partial duals” do not have access to full Medicaid benefits such as state plan services, behavioral health, care coordination, personal care and MLTSS which constitute most of the basis for the Medicaid MCO contracts. (See **Preserving D-SNP Options for Partial Duals** farther below.)
  - **Contract Level Medicare Models of Care:** Under MLTSS programs designed for FBDEs, states generally require robust care coordination systems designed for MLTSS (and/or behavioral health services) which should be coordinated with the D-SNP’s Medicare MOC. However, Medicare MOCs and related data collection requirements are generally designed to encompass all members (at a contract level) so when members have such major differences in access to benefits, it is more complicated to design efficient Medicare MOCs that can coordinate well with state MLTSS program requirements.
  - **Contract Level Materials:** Integrated programs are also expected to produce integrated member materials and benefit summaries that are easier for members to understand. The difference in benefits also makes it more difficult to integrate and simplify materials and member communications which are generally standard across all Medicare enrollees and thus may not reflect important Medicaid nuances or can be confusing for those who lack access to most Medicaid benefits.

- **Lack of Dual Specific Data Collection:** Under Medicare requirements, performance and cost data must be collected across all D-SNP enrollees. When enrollment parameters differ, data may not be representative of the specific enrollees in the Medicaid program, making it more difficult to meet Medicaid expectations for sharing useful and meaningful data for overall evaluation of the integrated plan performance, and adding to duplicative or overlapping reporting requirements.

### **Beneficiary Enrollment and Performance Data**

It can also be challenging to obtain information necessary to determine to what extent misaligned enrollment is a problem in a state or nationally. This determination may require collecting additional information from states and matching Medicare enrollment information with Medicaid enrollment information. While states can request this information from D-SNPs operating in their state as part of their MIPPA contracts or from CMS for other types of Medicare plans, states may lack the resources or systems to match and keep track of all of the types of Medicare enrollment that their members are allowed to choose. Collecting and reporting this data nationally is dependent on the following:

- Does the state know to what degree enrollments are currently aligned or unaligned?
- Is this information important to them?
- Do states have systems to track and/or coordinate enrollment data between D-SNPs and other MA plans operating in their state and the Medicaid managed care program?
- If not, are they able to make this investment?

Further, it is important to note that additional challenges to integration and data collection may occur even when members are enrolled for both programs under the same plan sponsor. Many D-SNPs are operated by plan sponsors who operate multiple products (PBPs or Plan Benefit Packages) all under the same contract number. Features designed or data collected for CMS Medicare purposes at the contract level (such as CAHPs and Stars performance data and MOCs) may not align with the data and reporting needs of state Medicaid agencies because they include populations outside of their Medicaid enrollees, precluding efficient collection of data for both purposes and making plan performance for dually eligible members difficult to evaluate.

All of these issues are complex and fraught with political, market and operational barriers that may take years to resolve. Plans alone cannot fix them. Addressing these challenges requires states that are highly committed to integration, understand the role of enrollment alignment in integration, are willing to invest resources in solutions and can make sometimes difficult choices in addressing these challenges.

### ***Enrollment Alignment Tools and Best Practices:***

Aligning enrollment is often dependent on state leadership, policies and resources to partner effectively with plans. However, there are a number of existing tools that states and plans can use to work together toward increasing aligned enrollments, many of which are laid out in detail in the ICRC tip sheet “Promoting Aligned Enrollment found at

[https://www.integratedcareresourcecenter.com/PDFs/ICRC\\_D-SNP\\_Aligning\\_Enrollment.pdf](https://www.integratedcareresourcecenter.com/PDFs/ICRC_D-SNP_Aligning_Enrollment.pdf).

Some of these include:

- **Requirements to Offer a Corresponding D-SNP:** More states are beginning to require that Medicaid MCO plan sponsors chosen for MMLTSS programs also sponsor a corresponding D-SNP. To ensure support of ongoing enrollment alignment, it is important for states to also require that the corresponding D-SNP service area fully matches the Medicaid service area.



- **Early RFI and Procurement Coordination:** States can plan ahead for differences in procurement schedules by issuing a Medicaid RFI or RFP outlining basic Medicaid and MIPPA requirements for such D-SNPs in time for the CMS D-SNP application process (18-24 months years ahead of a planned enrollment date.) To make this work, the Medicaid RFP should also include a Medicaid implementation timeline that gives bidders enough time to get a companion D-SNP in place by the time it is required for purposes of the Medicaid program. This could mean, for example, putting the date for a required companion D-SNP a year or two after the initial implementation date for a new Medicaid MLTSS program. It might also entail delaying the mandatory enrollment date for dual eligible populations for a year or two, and/or delaying the coverage of some services, such as HCBS waiver services, so that coverage coincides with the availability of companion D-SNPs.
- **Shared NOIAs:** States can require that all plans share their Notice of Intent to Apply for Medicare (NOIA) with the state (with appropriate confidentiality protections) which includes enrollment parameters and proposed service areas. (NOIAs are due to CMS in the fall in the year prior to the D-SNP application, which is usually due in February.)
- **Matching Enrollment Parameters:** States can also require that D-SNP applications match Medicaid enrolled population “subset” parameters and service areas. Where D-SNPs are already in operation with enrollment parameters that differ from Medicaid’s, the state may require changes to the MIPPA contract to match Medicaid enrollment (which is typically limited to FBDEs). However, such changes can result in some enrollees losing access to the benefits of D-SNP enrollment. (See further discussion in **Preserving D-SNP Options for Partial Duals** below.)
- **Use of Separate PBPs:** Where such enrollment parameters would exclude some groups that could benefit from D-SNP enrollment but might have a different Medicaid benefit set or require a different MOC or care coordination approach for either Medicare or Medicaid, states could ask that the plan create a separate PBP to enable continued access to D-SNP benefits and enrollment for those beneficiaries.
- **Coordination of Enrollment Implementation Dates:** States and plans can coordinate implementation of marketing and enrollment into both programs. (Approved plans then would start for both programs in January of the following year with marketing beginning in the fall.)
- **Utilizing the Existing Infrastructure:** When there is already an existing infrastructure of Medicaid MCOs and D-SNPs, states can prioritize choosing qualified Medicaid MLTSS plan sponsors that have significant existing D-SNP enrollment in order to minimize disruption and maximize enrollment alignment by giving extra points for participating D-SNPs with significant enrollments. They can then auto-assign those enrollees into the Medicaid plan offered by the enrollee’s D-SNP to assure alignment and continuity (see below).
- **Medicaid Assignment and Auto-Enrollment:** While current authorities to require Medicare-Medicaid beneficiaries to enroll in a specific D-SNP are strictly limited, states can use Medicaid authorities to assign and auto-enroll or periodically reassign Medicaid enrollees to the Medicaid plan operated by the sponsor of their D-SNP of choice to maximize enrollment alignment. Though managed care enrollment may be mandatory, Medicaid assignment and auto-enrollment includes consumer protections for making plan choices prior to assignment and opportunities to opt out to change plans after enrollment.
- **Medicare Passive Enrollment:** New Medicare rules allow limited use of Medicare passive enrollment for continued access to integrated programs when an integrated plan leaves the market

or is not renewed or terminated. This provision is limited to FIDE SNPS and highly integrated D-SNPs. It requires state approval and is dependent on several conditions including a minimum 3 Star rating, similarity in networks and cost sharing, and provision of 60-day and 30-day notices describing enrollees' right to opt out and choose another plan, as well as the costs and benefits provided by the plan.

- **Default Enrollment:** New Medicare rules allow “default enrollment” of new Medicare-Medicaid beneficiaries for only those D-SNPs operated under the same parent company of their Medicaid MCO. This replaces a previous “seamless enrollment” rule provision suspended by CMS that had been available to all MA plans. State approval through the MIPPA contract along with state agreement to provide identification of newly eligible Medicare members to be notified is required. Qualified plans must have a minimum 3 Star rating (or no rating where allowed) and no enrollment limitations, and must provide a 60-day notice allowing the beneficiary to opt out that provides information about plan differences and their right to other available options. States may also choose to require that D-SNPs pursue this permission from CMS as a condition of their MIPPA contract.
- **Co-Marketing:** States can assist plans with co-marketing strategies such as education of Medicaid members about aligned Medicare choices through development and dissemination of co-branded member communications and marketing materials, state-sponsored mailings and information that support such integrated choices, and enhanced training for enrollment brokers, SHIPs or other sources of enrollment assistance.
- **Preserving D-SNP Options for Partial Duals:** Preserving D-SNP enrollment options for partial duals is important to both states and beneficiaries. Unlike regular MA-PDs, D-SNPs offer states and partial dually eligible beneficiaries the benefit of improved clinical systems through specially designed Models of Care including individual care plans, interdisciplinary care teams, care coordination, provider training and networks tailored to the needs of these low income beneficiaries. However, MedPAC and others have recommended that partial duals no longer be allowed to enroll in D-SNPs given the issues discussed above under mismatched enrollment parameters.
  - Use of Separate PBP for Partial Duals: One potential solution to this integration barrier is to facilitate enrollment of partial duals under separate Plan Benefit Packages especially designed for partial dual beneficiaries, while allowing reporting of some data elements to be separated by PBP under the contract when necessary to better reflect the differences in the two populations.
  - This option may become more attractive as additional opportunities for provision of supplemental benefits are implemented over the next few years. Since FBDEs have access to MLTSS benefits under Medicaid, but partial duals do not, benefit packages that provide a modest LTSS benefit to partial duals may be attractive to both beneficiaries and states, and separating the PBPs may be more cost effective. However, it remains unclear whether bid savings will be adequate to provide additional supplemental benefits while retaining others that beneficiaries have come to expect such as dental, vision and hearing care.
  - In addition, this could simplify contract requirements by enabling merger of MIPPA contracts and Medicaid contracts for FBDEs, while streamlining MIPPA contracts for the non-FBDE members.
- **C-SNPs and I-SNPs:** Integrated enrollment pathways for Medicare-Medicaid beneficiaries in these plans have not yet been developed. However, some of these plans serve large numbers of Medicare-Medicaid beneficiaries under the scope of their current CMS agreements and pathways for further integration for beneficiaries in these plans should be considered. For example, through the umbrella of one plan sponsor and carefully designed agreements plans may find ways to

restructure relationships among these products to allow Medicare-Medicaid beneficiaries to take advantage of relevant models of care or special features while remaining attached to an integrated Medicaid plan, MMP or D-SNP.

## ***Recommendations***

These problems and solutions stem from CMS and state policies and plan business decisions that have changed and evolved over many years. It may take considerable time to resolve them and to find additional ways to align enrollment. Recognizing that many states and plans are at different levels of coordination and integration by necessity, these tools for aligned enrollment are meant to enable incremental steps along the integration continuum. In the meantime, there are several recommendations that CMS could address that would enhance alignment and integration efforts including:

- CMS should work with states to develop ongoing automated file comparisons or other mechanisms for determining and reporting the number of Medicare-Medicaid beneficiaries enrolled in unrelated plans for Medicare and Medicaid.
- CMS should develop additional pathways to integration to enable states and plans to address situations where beneficiaries are enrolled in unrelated plans including the opportunity for:
  - Expansion of Medicare passive enrollment policies to allow auto-assignment of Medicare-Medicaid beneficiaries enrolled in Medicaid managed care plans into aligned D-SNPs with opt-out and intelligent assignment protections for the purpose of facilitating enrollment into the same plan sponsor for both Medicare and Medicaid services.
- CMS should consider providing additional incentives for states (such as grants) to assist them with resources and staffing needed to determine the extent of and to address enrollment misalignments in their programs.
- CMS could examine how recent SEP changes impact beneficiaries' ability to access enrollment in integrated programs and consider modifications as needed.

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