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What's Next?
Retaining the Successes of the Medicare-Medicaid Plan (MMP) Model

SNP Alliance

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Supported by the SNP Alliance, ATI Advisory undertook this study to identify opportunities for the Centers for Medicare & Medicaid Services (CMS) to support to support and facilitate smooth transitions for states and dually eligible individuals, out of the MMP.

BACKGROUND

In 2013, the Centers for Medicare & Medicaid Services (CMS) implemented the Medicare-Medicaid Plan (MMP) model to better integrate Medicare and Medicaid at the administrative, financial, and clinical levels, and allow states to share in Medicare savings. MMP sits within broader demonstration authority known as the Financial Alignment Initiative (FAI).[1]

The MMP model has been tested in ten states across eleven programs with varied results, but generally, strong stakeholder support. In addition to the MMP, the Medicare-Medicaid Coordination Office (MMCO) at CMS has offered certain administrative alignment flexibilities to states to reduce redundancy and burdens for dual eligible individuals, health plans, and states.

During the same time as the MMP, CMS rapidly expanded Medicare-Medicaid integration through Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), in part applying lessons learned from administrative alignment flexibilities tested in Minnesota. As a result, in the contract year (CY) 2023 Medicare Advantage and Part D (MAPD) final rule, CMS noted that the MMP model will sunset in 2025, with future integration efforts emphasizing D-SNP. D-SNP does not have the full infrastructure of opportunities available through MMP, but it has advanced in recent years, including through the CY2023 MAPD final rule.

With the approaching MMP sunset, states are at varying stages regarding how to continue providing integrated care experiences for their dual eligible population absent the MMP. CMS has an important opportunity to work with states during this transition to ensure MMP best practices and lessons learned are not lost.

FINDINGS AND RECOMMENDATIONS

We reviewed relevant statute, regulation, guidance, and MMP state materials. This was supplemented by interviews with plan representatives, state officials, and policy experts. Interviewees generally did not want to sunset MMP and offered insights across the model's attributes that were most meaningful to integration, including **program oversight, enrollment, marketing and communications, beneficiary protections and access to care, and high-value experiences**. We identified the following policy paths for CMS to consider with the transition of the MMP, to protect dual eligible individuals and allow administrative simplification for states, plans, and CMS:

1. **Issue guidance and example State Medicaid Agency Contract (SMAC) language for implementing MMP best practices**. States remain unclear about how to operationalize certain functions outside the MMP and would benefit from draft contract language and implementation support. This would also streamline approaches across states, creating more equitable experiences for individuals.

2. **Create a "menu" of regulatory flexibilities available to states with integration**. Many MMP attributes are possible through administrative authority. Creating a package or menu of regulatory flexibilities would make it easier for states to implement these attributes holistically, and maximize beneficiary access to integration across states.

3. **Recognize the key statutory barriers that will return with the sunset of the MMP, and design a new 1115A demonstration using a D-SNP/Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) foundation**. Example opportunities include program financing. In addition, Congress should consider legislation to advance Medicare-Medicaid integration.

1 This document uses the term MMP model/MMP as shorthand for the capitated financial alignment model developed by CMS. The capitated financial alignment model is one of two financial alignment models under the FAI, the other being the managed FFS financial alignment model.

MMP Component: Program Oversight

Managed care plans typically are subject to different and sometimes conflicting requirements from CMS and the states in which they operate. This creates administrative inefficiencies for health plans, as well as barriers for states as they pursue integration with Medicare. **Key components of the MMP model that addressed these challenges include a three-way contract between CMS, a state, and an MMP; a contract management team; and data access and transparency.**

Contract Approach

Outside the MMP, health plans hold separate contracts with their state (Medicaid and D-SNP) and CMS (D-SNP/Medicare Advantage), which may conflict or have redundancy. The MMP model's three-way contract structure between CMS, the state, and the health plan, as well as the memorandum of understanding (MOU) used by Minnesota and CMS, allowed for efficiencies and administrative simplification, and provided states with a tool to enforce Medicare-related contract provisions.

Regulatory Opportunity
CMS should use a contract approach that allows for joint state and CMS oversight and ensures states can implement their policy goals. Example approaches include an MOU, a three-way contract or agreement, or certifying language in SMACs to validate state authority.

Contract Management Team (CMT)

States typically work with separate Medicaid and Medicare offices at CMS, which can create administrative challenges and conflicts, for example, if CMS approves a D-SNP bid without considering state policy that limits the D-SNP to certain counties. In addition, states are uncertain of their authority to administer or oversee Medicare provisions or may be unaware of impending Medicare policy change that intersects or interferes with state integration approaches. The MMP CMT is key to the program's success and helping states problem solve. The CMT includes representatives from both the state and CMS, and allows for ongoing collaboration between a state, CMS, and as needed, a health plan. The CMT also conducts contract management activities including ensuring access and quality. In study interviews, the CMT and ongoing communication with CMS was named as the MMP function stakeholders were particularly concerned to lose with the MMP transition.

Guidance and SMAC Opportunity
States can partner with CMS through a "modified" D-SNP CMT to improve collaboration and support oversight. CMS should ensure states are aware they can leverage a CMT as part of D-SNP programs. These should be staffed by a representative from the state and a representative from MMCO.

> ***Legislative Consideration: MMCO will likely need additional resources to staff CMTs across states.***

State Access to Data

To fully administer an integrated program, states need line of sight into plan experiences across Medicare and Medicaid, including Medicare eligibility and enrollment information, benefit design, encounter data, compliance, performance, and beneficiary level risk scores and payment. Much of this information is available through the Health Plan Management System (HPMS). States typically do not have access to HPMS despite opportunities for HPMS to allow enhanced oversight. Another important CMS system is Medicare Advantage/ Prescription Drug System (MARx), which provides detailed information on Medicare eligibility. States participating in the MMP were afforded access to these systems to facilitate eligibility processing and joint CMS-state review of MMP marketing and enrollee communications materials. States also accessed complaints data via the Complaint Tracking Module (CTM) in HPMS. CMS expanded access to HPMS to certain states using exclusively aligned enrollment in their D-SNP program, via the CY2023 MAPD final rule.

Regulatory Opportunity
CMS should provide HPMS access to all states, beyond those with exclusively aligned enrollment.

Guidance and SMAC Opportunity
States can require D-SNPs to provide the state with access to certain modules in the plan's HPMS account, or alternatively, provide or report oversight-related information to the state, such as corrective action plans, complaints, and materials.

MMP Component: Enrollment

Dual eligible individuals are subject to multiple and often conflicting enrollment periods, timelines, and processes between the Medicaid and Medicare programs. **The MMP model created streamlined processes to address these discrepancies including an integrated enrollment process with a single enrollment date across Medicare and Medicaid, and passive enrollment.**

Timing and Process

Enrollment periods and processes often conflict between Medicare and Medicaid. Medicare has multiple enrollment periods with consistent annual dates, including quarterly Special Election Periods (SEPs), Open Enrollment Periods, and Medicare Advantage Open Enrollment Periods. In Medicaid, however, enrollment and recertification dates vary by state, county, and program. In addition, Medicare enrollment typically is effectuated the first day of the month following the individual's enrollment action, whereas Medicaid enrollment effectuation may be immediate. This can create misaligned coverage months and waiting periods for dual eligible individuals. Also, Medicare enrollment form changes may occur without considering what information states are also collecting. To test a more seamless enrollment experience for dual eligible individuals, the MMP model allowed individuals to enroll in a single MMP and effectuation dates for MMP (dis)enrollments were aligned between Medicare and Medicaid. CMS and participating states also developed a single set of (dis)enrollment forms and other documents, and states were permitted to use a monthly SEP rather than quarterly SEP.

Guidance and SMAC Opportunity

CMS should issue state guidance on approaches to integrated enrollment processing, such as state use of a Third-party administrator (TPA) contract and integrated enrollment forms.

Regulatory Opportunity

Because the SEP is codified in regulation, CMS should allow integrated states to elect for ongoing/monthly SEPs.

> ***Legislative Consideration: Most Medicare enrollment periods are defined in statute.***

Best Practice

Minnesota provides D-SNPs with a third-party administrator (TPA) service, through which the state effectuates both the Medicare and Medicaid enrollment. This results in matching dates across the programs.

Facilitated Enrollment

The "default" coverage for dual eligible individuals is uncoordinated fee-for-service (FFS), and the process for choosing a Medicare Advantage option is confusing, with dozens of choices per county, the majority of which are not integrated. In addition, current supports and resources are not designed to facilitate choosing an integrated option. To address these challenges, participating states were permitted to passively enroll eligible individuals into an MMP, with the ability for individuals to opt-out. Outside the MMP, CMS has incrementally facilitated enrollment into integrated programs, for example, limited passive enrollment to preserve continuity of care and default enrollment for new-to-Medicare dual eligible individuals. In interviews, MMP states reported concern with the loss of passive enrollment. States were also unclear on the different roles of agents and enrollment brokers, and whether they needed to preserve an enrollment broker role following the transition of the MMP.

Guidance and SMAC Opportunity

CMS should issue state guidance on the role of Medicaid and Medicare enrollment brokers outside the MMP. States would also benefit from guidance on educating brokers and counselors about integrated programs and best practices on branding integrated programs.

Regulatory Opportunity

CMS can expand default enrollment to a broader set of circumstances and can expand passive enrollment with opt-out to individuals in FFS to promote integrated care and continuity between programs.

MMP Component: Marketing and Communications

The Medicare and Medicaid programs each have their own requirements regarding member communications and customer service, including member materials, marketing, and appeals and grievances rights. These requirements result in redundant and sometimes contradictory processes and experiences for dual eligible individuals. **The MMP included a joint review process and integrated materials.**

Integrated Materials, Communications, and Customer Service

Member communication (including written materials, verbal communication, and customer service) is a critical connection point between an individual and their plan, the state, or provider that ensures an individual understands their benefits, the providers they can access, and their rights. Because of this, uncoordinated communication and customer service negatively impact a dual eligible individual's program experience and access to care. For example, it can result in redundant and sometime conflicting notifications, potentially incorrect information due to different coverage rules between Medicare and Medicaid, and confusion regarding which providers an individual can access.

This is exacerbated by the different managed care marketing requirements and approval processes between Medicare and Medicaid, which can create conflict, confusion, and administrative burdens for states and plans. For example, the timing of CMS' release of model materials may be too late in the year for a state to adjust its own materials requirements and review processes. As another example, recent CMS regulation mandated a multi-language insert as part of Medicare Advantage communications materials, but the regulation did not acknowledge similar requirements in Medicaid managed care or the potential conflict between program regulations.

To address these types of discrepancies, CMS and MMP participating states developed a joint review process across Medicare and Medicaid. Participating MMP states also require that MMPs provide a single ID card, and an integrated member handbook, provider directory, and formulary. Focus groups on the MMP demonstration identified that a single member identification card was one of the key advantages of integrated program design.

Guidance and SMAC Opportunities

States can promote integrated member communications through the SMAC, for example, requiring D-SNP call centers to be knowledgeable about both Medicare and Medicaid or hosting a separate hotline/phone number specific for dual eligible individuals.

In addition, CMS should issue best practices on marketing approaches that facilitate enrollment in integrated plans, for example, states allowing D-SNPs to market directly to their Medicaid membership.

Regulatory Opportunity

CMS should expand its pilot testing of integrated model materials to additional states with integrated programs.

CMS should also allow states to modify the specific language requirements in Medicare Advantage communications based on local linguistic needs, and in alignment with Medicaid regulation.

Best Practice

CMS is piloting an approach to provide states with access to model materials (summary of benefits, list of covered drugs, and provider/pharmacy directories) prior to public release to Medicare Advantage plans. States using integrated materials can incorporate state requirements into the models and issue the model materials directly to D-SNPs.

As another best practice, Idaho requires D-SNP call center staff to be knowledgeable in both Medicare and Medicaid, to triage questions across both programs. Call centers also must be able to "warm transfer" callers to providers and other outside entities.

MMP Component: Beneficiary Protections and Access to Care

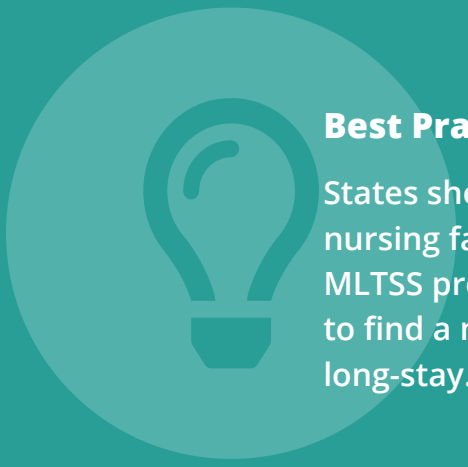
Dual eligible individuals experience access barriers and program confusion at high rates due to conflicting program rules between Medicare and Medicaid. In addition, these individuals are vulnerable to misinformation as a result of program support entities and other stakeholders that may understand one program (Medicare or Medicaid), but not both. **MMPs were subject to integrated network requirements. In addition, MMP model states received funding for ombuds supports.**

Network

Dual eligible individuals often must navigate two distinct provider networks, with providers that may accept only Medicare or only Medicaid. In addition, Medicare Advantage network standards and assessments reflect the general Medicare population (not dual eligible individuals) and encompass a Medicare Advantage organization's full contract. In instances where a Medicare Advantage plan is unable to meet local network adequacy standards, the plan can submit an exception request explaining how it intends to meet local need. CMS, not states, reviews Medicare Advantage networks and related exceptions requests. As a result, states are often unaware of whether an organization's network can meet the needs of dual eligible individuals. To address this, the MMP included dual eligible Medicare network standards and incorporated state review into related network exception requests. This allowed for a local perspective on patterns of care and provider supply.

Guidance and SMAC Opportunity
States can require D-SNPs to submit Medicare networks to the state for targeted review, (e.g., requiring overlap with Medicaid providers, cultural competence, or that D-SNPs contract with specific provider types beyond those in Medicare).

Regulatory Opportunity
CMS can develop D-SNP network standards at the plan level (beyond states with D-SNPs on a single contract), with state certification and revised network templates/ fields. As an example, CMS reviews Provider Specific Plan networks, which are a subset of a Medicare Advantage contract network.



Best Practice

States should encourage D-SNPs to ensure contracted skilled nursing facilities also participate in Medicaid and in the D-SNP's MLTSS product, to prevent dual eligible individuals from having to find a new facilities when a post-acute short stay transitions to long-stay.

Ombuds Program

All states have an Office of the State Long-Term Care (LTC) Ombudsman, providing statewide support to residents of long-term care facilities. Many states extend these services to individuals receiving long-term services and supports (LTSS) in their home or community. MMP-participating state also have an ombuds program in place to ensure robust beneficiary protection and support specific to dual eligible individuals. Across participating states, ombuds programs served as a singular, central contact for dual eligible individuals enrolled in MMP, empowering and supporting them in resolving issues in how they experienced services spanning health care, behavioral health, and LTSS. To support states, CMS provided funding for states to create or expand existing ombuds programs. This funding is limited to 1115A demonstrations and states currently cannot use it for D-SNP programs. In the absence of additional congressional funding, states are concerned they will have to sunset their dual eligible ombuds programs.

Guidance and SMAC Opportunity

States are permitted to expand LTC Ombuds services and receive Medicaid administrative funding for certain functions, including the explicit inclusion of dual eligible individuals. CMS should clarify to states that administrative funding is available for LTC Ombuds activities related to Medicare integration, including coordination efforts with the broader Aging and Disability network (e.g., Aging and Disability Resource Centers, State Health Insurance Programs).

MMP Component: High-value Experiences

The Medicare and Medicaid programs use various approaches to measure individuals' experiences and to ensure administering entities (such as health plans) are held accountable for delivering high-quality, high-value care. This is particularly important with dual eligible individuals, who are likely to face access barriers or receive care in inappropriate settings due to misaligned financial incentives. **The MMP included approaches across quality and financing to facilitate high-value experiences.**

Model of Care

The Model of Care (MOC) is a tool used by CMS to ensure special needs plans, including D-SNPs, can meet the unique needs of their enrollees. SNP MOCs undergo a rigorous evaluation and scoring process that does not occur in the MMP. In addition, states can inform MOC design based on Medicaid priorities.

Guidance and SMAC Opportunity

MMP states will need targeted support on MOC review and how elements of the MMP translate into D-SNP MOCs, as well as guidance on the extent of their ability to engage in MOC design.

Quality Reporting and Measurement

States have limited visibility into Medicare quality performance. States can leverage SMAC authority to align integrated reporting requirements for their D-SNPs and require additional data and information on Medicare services to the state, but must comply with Medicare reporting requirements and timelines. Additionally, Medicare quality measures may not reflect the behavioral, socioeconomic, or functional complexity of dual eligible individuals, leaving states to rely on measures for a broader and often healthier Medicare population. CMS and MMP states collaborate to ensure reporting requirements and processes across Medicare and Medicaid are coordinated to the extent possible, such as Healthcare Effectiveness Data and Information Set (HEDIS), Health Outcomes Survey (HOS), Consumer Assessment of Healthcare Providers & Systems (CAHPS) data, and quality improving activities.

Regulatory Opportunity

CMS should consider quality measures that reflect unique needs of dual eligible individuals, and consider how existing tools can flex to accommodate these unique needs. CMS also should align quality data collection methods and timelines across the programs, including opportunities to measure quality at the plan level.

Best Practice

States using exclusively aligned enrollment and a single contract can require D-SNPs to report one integrated Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey annually, rather than separate State and CMS CAHPS surveys.

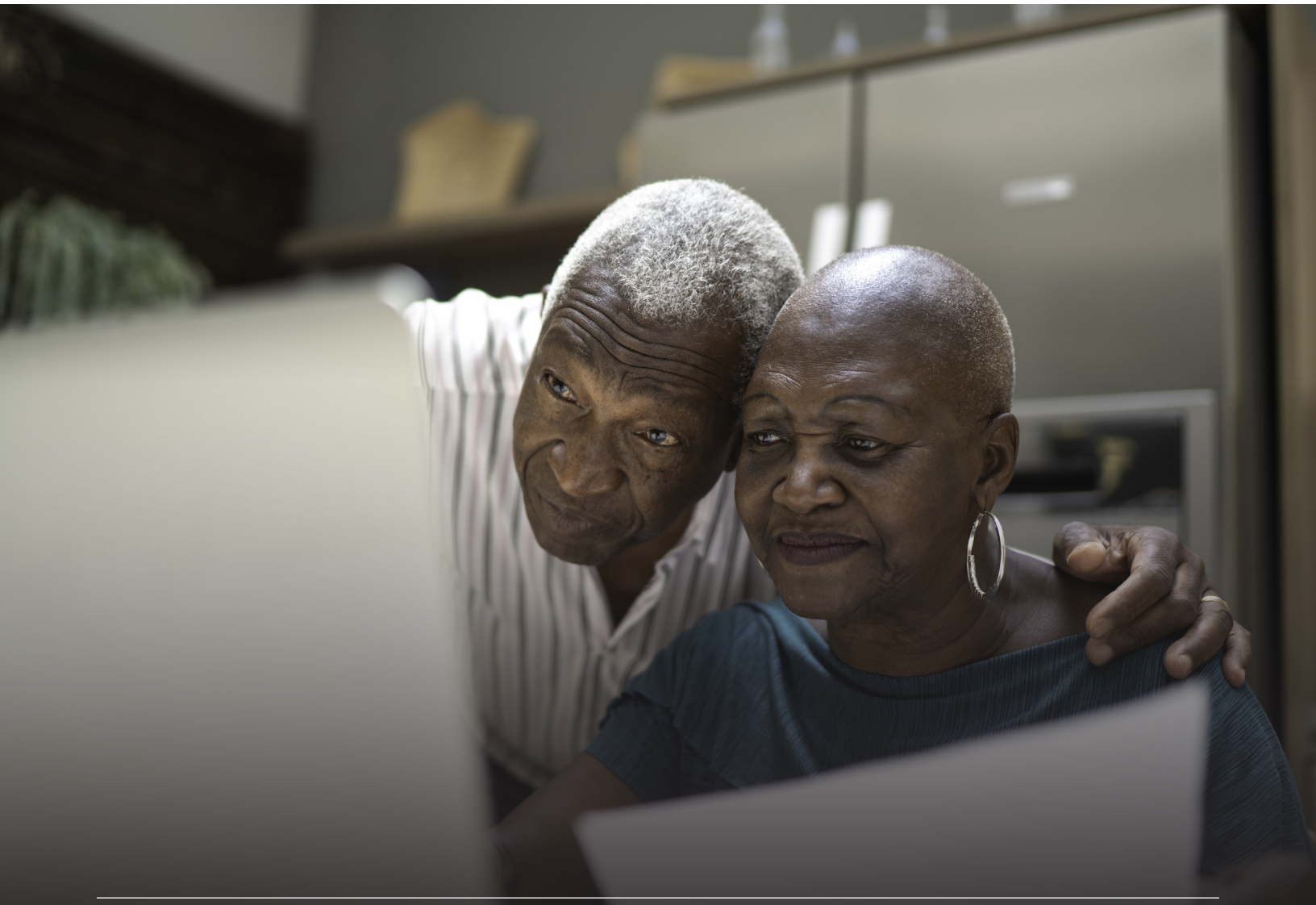
Program Financing

A key barrier to integration that MMP addressed is the financing of Medicare services with Medicare dollars and Medicaid services with Medicaid dollars. In addition, spending oversight is bifurcated, with each program having its own financial oversight approaches such as Medical Loss Ratio (MLR) calculations and requirements and the Medicare margin test. This bifurcated approach does not consider the impacts of one payer on the other (e.g., improved Medicare outcomes due to Medicaid services, or vice versa). An unintended result is cost-shifting between the programs. In addition, the Medicare margin test creates disincentives to pursuing a FIDE SNP due to the intersection with legal entity requirements and potential margin compression, which may impede MMP transitions.

Guidance and SMAC Opportunity
States can request D-SNP financial information/ calculate a blended MLR.

Regulatory Opportunity
CMS should adjust the Medicare margin test to remove disincentives associated with moving D-SNP enrollees to a Medicaid legal entity.

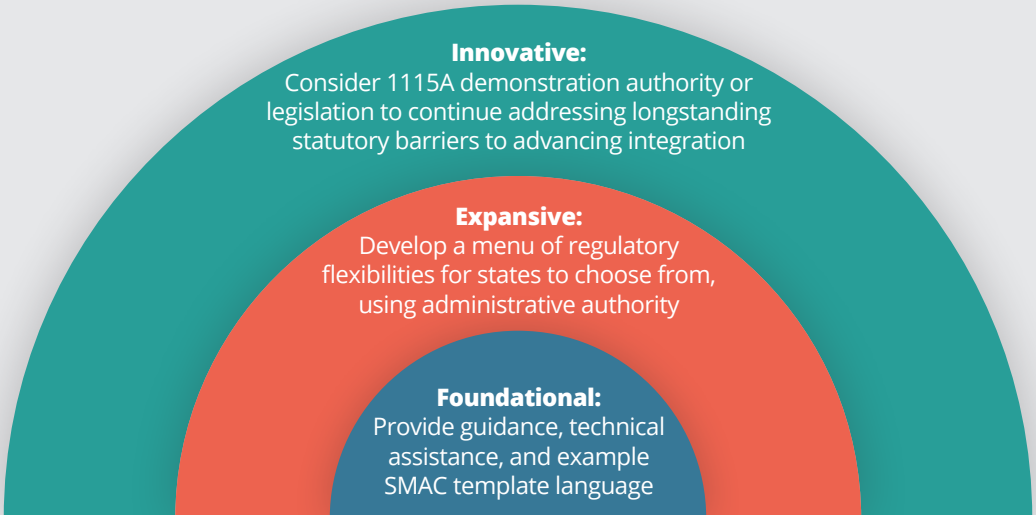
> ***Legislative Considerations: Shared savings and blended financing are inhibited by Medicare MLR definitions in statute and Medicaid Third-Party Liability (TPL) requirements.***



RECOMMENDATIONS

As CMS transitions MMPs into D-SNP related designs, it will be important to preserve lessons learned and strengths of the MMP that improved dual eligible experiences and reduced administrative burdens. CMS has existing authority to maintain a considerable portion of these attributes, and should seek to preserve the attributes that are in statute through a refined, innovative financial model.

Through our research, we identified three policy approaches CMS and lawmakers should consider. These should be approached collectively to maximize access to meaningfully integrated programs:



1. **Provide foundational guidance, technical assistance, and example SMAC template language.** States reported uncertainty regarding how certain functions in the MMP will occur in D-SNPs, such as the use of enrollment brokers and data transfer. In addition, different MMPs had key best practices (such as continuity of care provisions) that are possible without administrative action. CMS should issue example SMAC contract language to reflect these best practices and streamline approaches. In addition, CMS should assist states with how to implement and administer these program features outside MMP, including in states with FFS Medicaid.

2. **Develop a "menu" of regulatory flexibilities for states to choose from.** Many of the MMP model flexibilities are attainable through existing administrative authority. CMS could create a template to guide states through the integration policies eligible to them, based on their underlying program structure. This would facilitate state actions and maximize consistency in program design and access across states.

3. **Consider 1115A demonstration authority or legislation to continue advancing integration.** Certain statutory provisions inhibit true integration, such as siloed financing and MLR definitions. CMS should consider testing a refined financial approach with states, on a D-SNP/FIDE SNP foundation, which could include state upside and downside risk. Congress should ensure MMCO and states are resourced to pursue integration, and revisit the statutory requirement that Medicaid must be the payer of last resort, to ensure it does not interfere with integrated program design and payment.

Recommendation 1:

Provide Guidance, Technical Assistance, and SMAC Template Language

States report uncertainty regarding whether or how certain MMP functions will occur in D-SNPs. In addition, MMPs had key best practices (such as continuity of care provisions) that are possible without administrative action. **CMS should issue example/template SMAC contract language to reflect these best practices and streamline approaches across states. CMS also should assist states with how to implement/administer these program features outside MMP.**

Provision	Considerations
Contract Management Team (CMT)	Some states have developed a modified CMT using a D-SNP framework (e.g., Minnesota, Virginia). CMS should educate other states on this approaches. CMS may to adjust internal review processes across its Medicaid, Medicare, and dual eligible offices to accommodate. *Likely Congressional Action: Staffing CMTs across every state will require resources*
Access to Data	Via the SMAC or MCO contracting arrangements, states can request access to data. For example, Minnesota's Third-Party Administrator (TPA) contract states: *The MCO will allow the STATE to: (a) register as a Health Plan Management System (HPMS) user to receive HPMS Enrollment and Systems related memos; (b) register as a plan representative for continued access to CMS system calls; and (c) have continued submitter and user representative access to MARx, enrollment applications as needed, and to all files as specified [elsewhere].*
Enrollment Timing and Process	CMS should issue state guidance and example SMAC language on approaches to integrated enrollment processing, such as state use of a TPA contract and integrated enrollment forms. In addition, CMS should issue guidance to states on the role of Medicaid enrollment brokers, and Medicare agents and brokers, and what these roles mean without the MMP.
Member Communications	MMCO should educate states on best practices and expectations in aligning customer service experiences for dual eligible individuals. For example, Idaho requires D-SNPs to ensure call center staff are educated in Medicare and Medicaid. In addition, CMS should educate states on best practices around marketing to Medicaid membership to grow enrollment in an associated D-SNP overtime. States also could issue state letters and joint materials with plans, to educate dual eligible individuals on the value of integrated care.

Recommendation 1, continued...

Provision	Considerations
Provider Network	MMCO should provide SMAC language for states interested in requiring D-SNPs to submit Medicare networks to the state for tailored review. This might include a certain overlap in Medicare and Medicaid providers, or that D-SNPs contract with specific provider types beyond those in Medicare. For example, California requires: *Upon execution of this D-SNP Contract and annually thereafter, D-SNP Contractor shall submit to DHCS a report that outlines D-SNP Contractor's full Medi-Cal provider network within the defined Service Area... ...also be responsible for meeting network adequacy and aligned network requirements as detailed in CalAIM D-SNP Policy Guide issued by DHCS.*
Ombuds	CMS should clarify to states that administrative funding is available for LTC Ombuds activities related to Medicare integration, including coordination efforts with the broader Aging and Disability network (e.g., ADRCs, SHIPs). Current guidance is unclear.
Model of Care (MOC)	CMS should issue guidance on the extent of state authority to influence and engage in D-SNP MOC design. In addition, transitioning MMP states will need targeted support on MOC review and how elements of the MMP translate into D-SNP MOCs. California, for example, requires that certain D-SNPs implement state-specific care coordination requirements in their MOCs starting in 2023. These state-specific requirements fall under: Risk Stratification, Health Risk Assessments, Individualized Care Plans and Interdisciplinary Care Teams, and Care Transitions.
Financing	States can request financial information from D-SNPs and create a blended Medical Loss Ratio (MLR). CMS should educate states on their Medicaid MLR authority, such as whether and how to require program reinvestments or remittances based on a blended MLR. CMS should also educate states on how to align Medicaid MLR calculation with Medicare MLR methods (e.g., accounting for D-SNP supplemental benefits that overlap with Medicaid services, or other differences in numerator calculation of each program's MLR).

Recommendation 2:

Develop a Regulatory Menu of Integration Options

Many MMP flexibilities are currently possible through existing administrative authority. Similar to the approach CMS is taking with its "single contract pathway" creating a set of opportunities for states using exclusively aligned enrollment (such as a blended MLR, integrated materials, and access to HPMS), **CMS could create a menu of regulatory flexibilities for states pursuing integration. Such a menu would create a package of options to facilitate state understanding and uptake of regulatory flexibilities that help to continue MMP-like experiences.**

Provision	Considerations
Contract Structure	CMS could use a contract approach that allows for joint state and CMS oversight and ensures states can implement their policy goals. Example approaches include an MOU, a three-way agreement, or certifying language in SMACs that validates state authority over Medicare provisions. Because current Medicare Advantage contracts and approvals occur at the "contract ID" level, CMS would need to change existing process or limit to states using the single contract pathway.
State Access to Data	States meeting a pre-defined level of integration (potential to expand beyond states requiring single contract IDs) would have access to HPMS, its included modules, and MARx. This would reduce burdens associated with requesting data from D-SNPs. States can also accomplish this through SMAC or MCO contract provisions.
Enrollment Processes	States meeting a pre-defined level of integration would be permitted to allow ongoing/ monthly Special Election Periods (SEPs), similar to the process that existed prior to 2019.
Facilitated Enrollment	States would be permitted to extend default enrollment to any individuals who became Medicare eligible in a set number of years (e.g., three) preceding implementation of default enrollment. Default enrollment would also include dual eligible individuals shifting into Medicaid managed care; at the transition into managed care the individual would be default enrolled into an integrated product. CMS also would expand passive enrollment with opt-out to preserve choice. This would be in the spirit of integrated care and extend to any dual eligible individual currently in Medicare FFS.

Recommendation 2, continued...

Provision	Considerations
Member Materials and Communication	CMS should expand its pilot testing of integrated model materials to additional states with integrated programs. The current Paperwork Reduction Act notice on integrated materials would allow for this expansion related to specific materials and could have a meaningful impact on dual eligible individual experiences. CMS should also allow states to modify the specific language requirements in Medicare Advantage communications based on local linguistic needs, in alignment with Medicaid regulation.
Provider Network	CMS can develop D-SNP-specific network standards and review processes tailored to dual eligible individuals, with state review or certification. For example, network standards would be based on locations and number of dual eligible individuals and adjusted to reflect their utilization patterns. CMS also could add a field in network tables to denote providers that participate in Medicaid. To accomplish this, CMS could review D-SNP networks at a plan level, similar to Provider Specific Plans.
Quality Reporting and Measurement	CMS should continue to explore quality measures that reflect the unique circumstances of dual eligible individuals. This includes aligning quality data collection methods and timelines across the Medicare and Medicaid programs, such as measuring quality at the plan level for states with integrated programs.
Financing	CMS should adjust the Medicare margin test to remove disincentives associated with moving D-SNP enrollees to a Medicaid legal entity. Because of the calculation at the bid and aggregate level, plans may experience margin compression when shifting D-SNP enrollment, which may interfere with MMP transitions.

Recommendation 3:

Consider Legislative Change or 1115A Authority Atop a D-SNP Program

While the regulatory environment has advanced considerably in recent years, certain statutory provisions continue to inhibit true integration, such as siloed financing and MLR definitions. The MMP waived many of these provisions, and the loss of these waivers with the MMP sunset could impede and even reverse some of the integration gains made through the demonstration.

Provision	Considerations
Enrollment Timing and Process	CMS should continue to conditionally waive statutory and regulatory requirements that create barriers for states wanting to align their D-SNP and state Medicaid managed care enrollment periods. This includes Medicare enrollment periods that are defined in statute.
Financing	CMS should continue to waive Medicare MLR provisions to allow states with flexibility to understand the total cost of care for dual eligible individuals. In addition, CMS should consider a novel approach to "blending" Medicare and Medicaid financing, for example, including shared risk as well as shared savings between states and CMS. CMS could compare program experiences, including quality and overall spending, to dual eligible individuals in D-SNPs not participating in the model.

Congressional Opportunities

In addition to 1115A opportunities, there are legislative barriers and opportunities to improve integration that are outside demonstration authority. For example:

- An integration barrier that remained even with the MMP was the requirement for plans to encounter their experiences separately to CMS and states (i.e., encounter Medicare experiences associated with Medicare dollars to CMS, and Medicare experiences associated with Medicaid dollars to the state). To accomplish real blending of finances, Congress should reevaluate Medicaid third party liability provisions that result in disparate reporting requirements across Medicare and Medicaid (to assure Medicaid is the payer of last resort), or alternatively, include these provisions in CMMI authority to waive and test demonstrations around.
- The Bipartisan Budget Act of 2018 provided additional authority to MMCO within CMS, but the extent of this authority is unclear and internal CMS barriers continue to impede integration. For example, multiple offices at CMS have different authority over D-SNP. Congress should clarify its intent that MMCO has authority over programs serving dual eligible individuals. In addition, Congress should provide additional funding to MMCO to allow the office to further develop integration approaches, such as staffing CMTs across states.
- States need resources to advance Medicare-Medicaid integration. Congress should incentivize states to invest in integrated models, for example, through grants and enhanced federal matching assistance percentage (FMAP) tied to integration strategies. Congress should also consider requiring states to have a Medicare-Medicaid integration strategy that builds on the foundation of MMP and D-SNP, which has been acknowledged in various currently proposed pieces of legislation.

CONCLUSION AND ABOUT THIS WORK

While stakeholders generally did not support a shift away from the MMP, taken together, the findings and recommendations identified in this study would help preserve many of the best practices and successes of the MMP. CMS has an important and critical opportunity to work with states to ensure Medicare-Medicaid integration and beneficiary experiences do not regress. In addition, it is important to preserve the administrative simplification afforded by the MMP, which benefited dual eligible individuals, health plans, states, and CMS. Congress also has an important role in advancing Medicare-Medicaid integration and program efficiencies, and should consider legislation to address the remaining statutory barriers to integration.

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ATI Advisory is a research services and advisory firm, focused on improving the care experience and financing of care for individuals across Medicare, Medicaid, and long-term services and supports. We work with states, health plans, providers, associations, and philanthropic organizations to advance healthcare innovations and system efficiencies, and to improve equitable and appropriate access to care and programs.
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SNP Alliance

The **SNP Alliance** is a national non-profit leadership organization dedicated to improving policy and practice for serving high risk and complex needs individuals through Medicare Advantage Special Needs Plans (SNPs) and Medicare-Medicaid Plans (MMPs). The SNP Alliance's 26 health plan organization members serve over 2.8 million special needs individuals in 47 states and the District of Columbia.
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