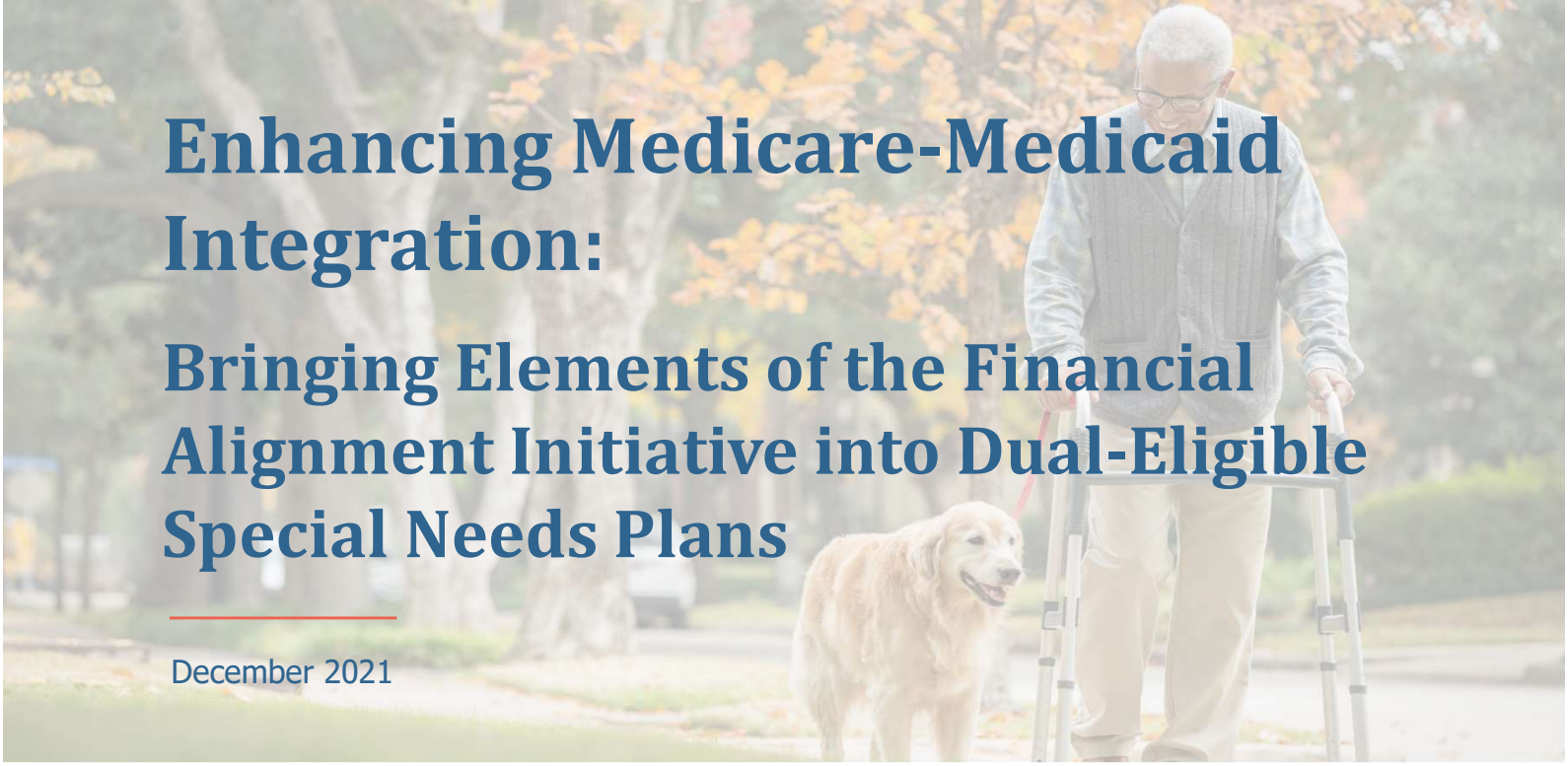


Enhancing Medicare-Medicaid Integration:

Bringing Elements of the Financial Alignment Initiative into Dual-Eligible Special Needs Plans

December 2021

Overview

Individuals dually eligible for Medicare and Medicaid typically must navigate a fragmented and sometime conflicting set of program requirements and processes. The Centers for Medicare & Medicaid Services (CMS), Congress, and states have developed numerous "integrated" programs to address this system complexity. The Financial Alignment Initiative (FAI), authorized through the Center for Medicare and Medicaid Innovation (CMMI), promotes the greatest amount of integration. However, the FAI currently is available in only 11 states, while other, lesser-integrated, programs are available almost nationwide. This limits access to integrated programs to a small subset of the 12 million dually eligible individuals.

In partnership with Arnold Ventures, ATI Advisory undertook this study to identify provisions in the FAI that CMS and/or Congress could extend to D-SNPs through rulemaking and legislation, or that states might consider implementing in D-SNPs through current authority.

Summary of Findings and Recommendations

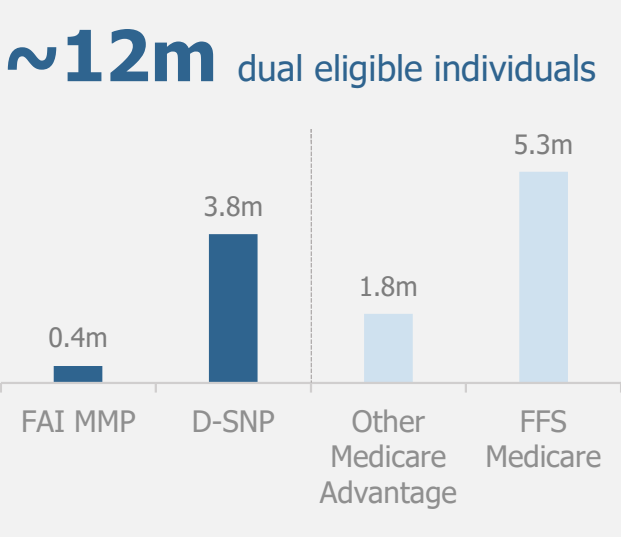
1. Many of the integration provisions available through the FAI are possible in Medicare Advantage Dual-eligible Special Needs Plans (D-SNPs) but states often do not realize the extent of the D-SNP authority. CMS should clarify to states how to accomplish FAI provisions using D-SNP contract authority and/or could require some of these provisions in D-SNP programs.

2. Through the Bipartisan Budget Act of 2018 (BBA 2018), the Medicare-Medicaid Coordination Office (MMCO) at CMS has broad authority to promote integration, but this authority has been minimally used outside the FAI. Congress should clarify the intent of this authority, and CMS should leverage this authority to scale FAI successes to the D-SNP program.

3. Models and demonstrations tested under CMMI authority can be expanded in duration, scope, or geography through rulemaking and without Congressional action. MMCO should explore whether elements of the FAI meet the spending and quality criteria required to expand provisions into the D-SNP program.

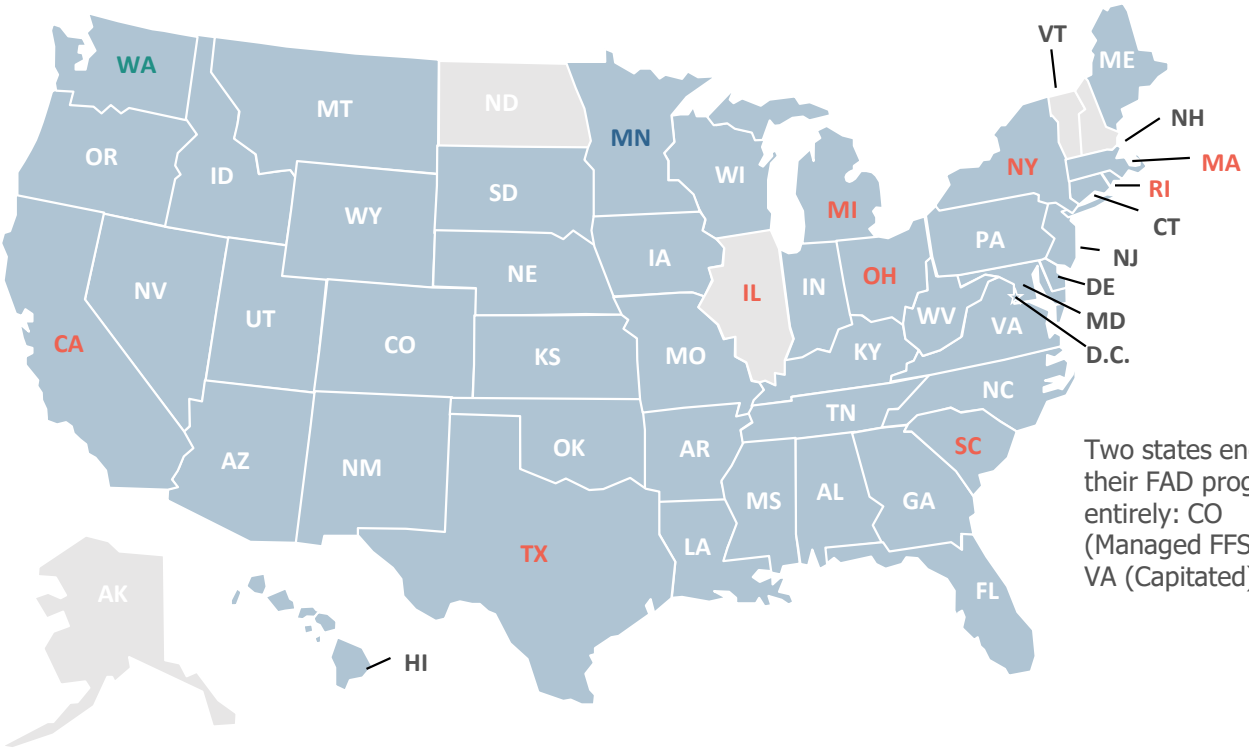
Issue Summary

Approximately 12 million individuals are dually eligible for Medicare and Medicaid ("dual eligible individuals"). Because the Medicare and Medicaid programs were not originally designed to work together, dual eligible individuals typically must navigate a complex and sometimes conflicting set of requirements and policies.



CMS, states, and health plans have been testing models to integrate and align the two programs since the 1990s. The most recent and significant effort, the Financial Alignment Initiative (FAI), tests integration at the administrative, financial, and clinical levels, and allows states to share in Medicare savings. However, the FAI serves a small fraction of dual eligible individuals compared to the Dual-eligible Special Needs Plan (D-SNP) program and remains a demonstration, limited to 11 states (Figure 1). Conversely, D-SNPs are permanently authorized and available in 47 states and territories as of 2022, creating the potential to be a more scalable and expansive platform through which to promote integration.

Figure 1: Integrated Program Model by State, 2022



Two states ended their FAD programs entirely: CO (Managed FFS) and VA (Capitated)

D-SNP	Managed FFS FAD	Administrative FAD	Capitated FAD
47 States	1 State	1 State	9 States

ATI ADVISORY
IDEAS TO ACTION IN HEALTHCARE & AGING

Enrollment data in bar chart from ATI Advisory analysis of November 2021 CMS enrollment files and Q1 2021 Master Beneficiary Summary File; numbers do not add to 12 million due to differences in reporting dates and rounding.
Program definitions (e.g., Capitated FAD) provided at the end of this document.

Study Background

CMS and state authority to integrate Medicare and Medicaid has evolved considerably since the D-SNP program was introduced in 2003 (Figure 2). However, this authority has not been used to its fullest extent. For example, the highest degree of integration occurs in the FAI, but most FAI provisions are not limited to demonstrations and could be required in D-SNP programs. To better understand and articulate the full scope of administrative flexibilities available through the FAI that CMS might bring into the D-SNP program, our team reviewed relevant statute, regulation, guidance, and FAI materials for all thirteen (13) current and former financial alignment demonstration (FAD) states, as well as CMMI Evaluation Reports. We supplemented our analysis with interviews with MMP representatives and state officials most involved in their state's FAD.

FAI flexibilities discussed in this brief are organized as follows:

- Enrollment
- Member Communications and Customer Service
- Financing and Payment
- Benefits and Model of Care
- Operations and Other Elements

Learnings from the FAI can be translated to the D-SNP through mandatory State Medicaid Agency Contracts (SMACs) and MMCO authority to regulate D-SNPs. However, few D-SNP programs leverage FAI provisions in part because it is challenging for states to come into compliance with Medicare. Further, MMCO has not leveraged its authority outside the FAI.

Figure 2: Recent Authorities and Milestones in Promoting Integration, by Year

2003	2008	2011	2018
D-SNP	MMCO	FAI	BBA
Medicare Advantage plan serving dual eligible individuals and that must contract with a State Medicaid Agency and coordinate Medicaid benefits for enrollees	CMS office established to improve quality and access to care, simplify processes, and eliminate regulatory conflicts and cost-shifting for dual eligible individuals	Demonstration model sponsored by MMCO that waives Medicare and Medicaid statutory provisions to improve alignment and integration	Legislation requiring enhanced integration for D-SNPs and establishing MMCO as the dedicated contact and authority with CMS to address D-SNP integration
Permanent	Permanent	Time-limited	Permanent
Established through MMA, §231; revised through MIPPA to require SMACs; other legislation to periodically extend the program; BBA to increase integration and permanently authorize.	Established through the ACA, §2602 and given expanded authority through the BBA of 2018, §50311	CMS Innovation Center Authority	BBA 2018, §50311

MMA – Medicare Prescription Drug, Improvement, and Modernization Act
MIPPA – Medicare Improvements for Patients and Providers Act
ACA – Affordable Care Act
BBA – Bipartisan Budget Act

Integration Flexibility: *Enrollment*

Dual eligible individuals are subject to multiple and often conflicting enrollment periods, timelines, and processes between the Medicaid and Medicare programs. The FAI created a streamlined processes to address these discrepancies that includes one set of materials, a single enrollment date across Medicare and Medicaid, and passive enrollment. To create similar alignment in D-SNP programs, states generally must come into compliance with Medicare enrollment periods and processes.

Non-FAI Medicaid		Non-FAI Medicare
Eligibility must be renewed at least every 12 months, or individual loses eligibility	Eligibility	**Aged-based eligibility** typically permanent; **disability and condition-based eligibility** may end if condition improves
Enrollment period dates vary by state, county, and Medicaid program	Enrollment Periods	**Multiple enrollment periods** typically with consistent annual dates, including quarterly Special Election Period, Open Enrollment Period and Medicare Advantage Open Enrollment period
Passive and mandatory enrollment often used to align individuals with certain programs and health plans	Passive & Mandatory Enrollment	**Mandatory enrollment into** Medicare Advantage not permitted; **Passive enrollment** limited to specific circumstances and programs
Independent choice counseling required; often use **independent enrollment broker**	Broker	**Commissioned agents, brokers, and sales staff** can generally promote any product

Provision	FAI Flexibility*	D-SNP Ability to Deploy Provision	Additional Policy Action Needed
Deemed Enrollment	Deemed enrollment is permitted (and optional) to help retain enrollees and maintain continuity of care during periods of temporary loss of Medicaid eligibility, often due to renewal delays. MMPs typically deploy a 2-3 month deeming window.	Deemed enrollment is **currently optional for D-SNPs** to include for up to 6 months. **Plans take financial responsibility for all Medicaid payments** made during a gap in eligibility if Medicaid eligibility is not restored. This occurs in both the FAI and D-SNP programs.	**(Sub)Regulatory** States and CMS could require deemed enrollment as part of D-SNP contract.

*Unless otherwise noted, FAI flexibilities detailed in this brief refer to capitated FADs and MMPs.

Provision	FAI Flexibility	D-SNP Ability to Deploy Provision	Additional Policy Action Needed
Integrated Enrollment Process	Enrollment materials are fully integrated between Medicare and Medicaid. Individuals enroll in a single MMP for both sets of benefits with aligned enrollment dates. In Minnesota, the state functions as the enrollment Third Party Administrator (TPA) which helps keep enrollment aligned, reduces enrollment discrepancies, and expedites eligibility reinstatement when a dual eligible individual temporarily loses Medicaid eligibility.	Integrated enrollment and enrollment materials in D-SNP are **currently possible but difficult. The burden of bringing materials and information technology systems into compliance with Medicare requirements falls on the state.** **States may work within their SMACs to require integrated enrollment materials** (e.g., one ID card, integrated Summary of Benefits) across all D-SNPs. This is easier to manage with exclusively aligned* D-SNPs. However, even with aligned materials and enrollment periods, individuals retain the choice to enroll in any Medicare product/ program and **agents typically are permitted to sell non-integrated products to dual eligible individuals**. Additionally, the Medicare.gov Plan Finder tool does not prioritize integrated products. Additionally, adding Medicaid information to existing Medicare material requirements **can result in confusing and sometime contradictory materials**.	**Regulatory** MMCO should use its BBA-provided authority to provide greater flexibility to states regarding enrollment procedures for members becoming newly Medicare eligible, for example, allowing a waiver of Medicare marketing timelines and content. CMS also could require plan enrollment channels (e.g., agents) to promote integrated products where available, or otherwise adjust agent commissions and payment based on enrollment in integrated products. CMS also could create a website and/or approach through Plan Finder for individuals to enroll in a single Medicare-Medicaid program. **Legislative** Certain provisions related to member materials are enumerated in law (Social Security Act §1851(h) and § 1860D-1(b)(1)(B)(vi)). Congress should grant MMCO flexibility to waive these provisions and exercise its BBA-provided authority to create an integrated review process and integrated materials for D-SNPs.
Passive Enrollment	Participating FAI states are permitted to passively enroll dual eligible individuals into MMP products. Enrollees are provided advance notice and may opt-out or disenroll at any point.	Passive enrollment into a D-SNP is **possible only in limited circumstances**. D-SNP passive enrollment is permitted in circumstances where existing enrollment in integrated care coverage is involuntarily disrupted (e.g., the individual's D-SNP is terminated); however, **few states have been successful in receiving approval for passive enrollment** even in this situation. Of note, D-SNPs also are eligible for default enrollment in certain circumstances, for newly Medicare-eligible individuals.	**Regulatory** Language in 42 CFR 422.60(g)(1)(iii) codifies CMS' authority to passively enroll individuals when it is necessary to promote "integrated care" and "continuity of care" for full benefit dual eligible individuals. CMS should reinterpret what qualifies as a situation necessary to promote integrated care and continuity of care, such that greater discretion is given to states to passively enroll dual-eligible individuals into integrated D-SNPs. This should extend to individuals becoming newly dually eligible.

*Exclusively aligned enrollment occurs when a D-SNP only enrolls individuals for which it also has Medicaid risk for long-term services and supports and/or behavioral health.

Integration Flexibility : *Financing and Payment*

Misaligned financial incentives between Medicaid and Medicare can contribute to cost-shifting between the programs, as well as duplicative service, unmet needs, and receiving care in inappropriate settings. It can also create an environment where services in one program are underfunded, while those in the other program indirectly subsidize this underfunding. Processes related to financing and payment (e.g., claims and encounters submission) also can create administrative burdens for providers and health plans serving dual eligible individuals.

The FAI sought to address these misalignments through blended payments to and oversight of health plans. Financing and payment is the key area where legislation may be required to allow states to apply FAI flexibilities to their D-SNP programs, depending on Congress and CMS' interpretation of the authority granted to MMCO through the BBA.

Provision	FAI Flexibility	D-SNP Ability to Deploy Provision	Additional Policy Action Needed
Integrated Provider Claims	Integrated claims reporting and processing are uncommon but are used by some FAI programs. Minnesota leverages a long-standing (pre-FAI) integrated claims adjudication process, through which D-SNPs receive a cost-sharing payment from the state and process integrated set of claims for services that include both payers, to reduce the need for provider crossover claims. D-SNPs must submit both Medicaid and Medicare encounters to the state.	States **currently can accomplish an integrated provider claims process** by having the D-SNP be liable for cost-sharing payments otherwise paid for by the state. Additionally or alternatively, a state can require the D-SNP to adjudicate the Medicaid portion of the claim with the state, minimizing the burden on the provider. Further, D-SNPs that also have a Medicaid managed care contract **can use Medicare and Medicaid dollars to provide a benefit that, on an actuarial basis, equals the value of the benefit from the combination of both funding streams**. However, even with integrated provider claims to health plans and combined funding, **plans are still required to *encounter* these expenses separately** to CMS and the state, undermining a truly integrated experience.	**Legislative** Congress should consider an approach similar to §1894(f)(2)(B) and §1934(f)(2)(B)of the Social Security Act (which allow PACE organizations a capitated, integrated financing payment) for fully-integrated D-SNPs, and/or refine Medicaid Third Party Liability requirements at §1902(a)(25) in the Social Security Act to allow for integrated encountering.
Shared Savings	Capitation rates for participating MMPs are developed based on baseline spending in both Medicare and Medicaid and anticipated savings that might result from integrated care. Aggregate savings compared to baseline costs are shared proportionally by both states and CMS.	States **can indirectly share in Medicare savings by:** • Determining D-SNP supplemental benefit design, for example if the benefits overlap with covered Medicaid services, as supplemental benefits typically are funded through Medicare savings to the D-SNP and become primary to Medicaid. • Adjusting base data used for Medicaid rate development to address coordination of benefits, such as when both Medicare Advantage and Medicaid cover a benefit. However, **these approaches are indirect and limited** in nature, and it is unclear whether a state can directly share in savings.	**Guidance** MMCO should issue guidance to states on specific approaches for sharing in Medicare savings. **Regulatory** MMCO could explore its BBA-provided authority to determine whether benchmark payments to D-SNPs can incorporate a savings assumption to be shared with the state in states that pursue fully-integrated D-SNPs.

Provision	FAI Flexibility	D-SNP Ability to Deploy Provision	Additional Policy Action Needed
Quality Withholds	CMS and states withhold a portion of the Medicare and Medicaid FAD capitation payment, ranging from one to five percent. MMPs may earn back the withheld amount upon meeting certain quality thresholds. If the MMP achieves its measures, the withheld amount is repaid retrospectively.	Quality payment in the D-SNP program are *additive* through Star Rating bonuses. It is **unclear whether states can withhold Medicare payment**; however, **states currently can influence quality** which is a key goal of a quality withhold. As an example, D-SNPs can be required to maintain a Star Rating at a certain threshold, reach specific state quality targets, and report quality data to the state. However, the current MA Star Rating system assigns ratings at the contract level. Most contracts contain several plans (D-SNP and non-D-SNP), and all plans within a contract are combined when calculating the Star Rating, making it difficult for states to understand D-SNP performance.	**Guidance** CMS should issue guidance to states on administering D-SNP programs at the contract level rather than plan ID level. CMS mentioned this approach in the 2023 Medicare Advantage Notice of Intent to Apply, but states would benefit from guidance on the process and implications.
Medical Loss Ratio (MLR)	FAD states are permitted to set minimum, integrated MLRs for MMPs. CMS and states recoup a payback from MMPs failing to meet the standard.	Medicare Advantage plans must maintain a federal minimum MLR of 85%. Separately, a state can mandate a minimum Medicaid MLR for Medicaid managed care plans. **States currently can enforce actions based on D-SNP Medicare or integrated MLR requirements**, for example freezing enrollment at certain thresholds. However, while a state can rebase Medicaid capitation payments based on coordination of benefits with Medicare, no such process exists in calculating and enforcing the MLR. This creates challenges with rebasing Medicaid rates if Medicaid MLRs do not account for Medicare payment and spend.	**Regulatory** MMCO should explore its BBA-provided authority to determine whether states/CMS can allow a blended MLR for D-SNPs, inclusive of their Medicaid and Medicare expenditures. This likely requires assessment of Medicaid TPA laws at §1902(a)(25) in the Social Security Act as well as alignment in timing of MLR data collection across the programs. At a minimum, CMS can require plans to submit blended MLRs, e.g., as part of the Medicare Advantage margin test.
Alternative Payment Methods (APMs)	While not widespread across the FAI, Michigan and Minnesota leverage APMs to advance integration, incentivize quality care, and improve health outcomes.	States can **require D-SNP to improve quality outcomes** and can **"set minimum payment amounts"*** for providers. However, it is unclear to what extent states can require D-SNPs to adopt integrated APMs (e.g., using Medicare savings to incentivize Medicaid providers).	**Guidance** MMCO should clarify whether states can require D-SNPs to develop APMs that recognize the full delivery system (acute and long-term) and provide examples of how states can accomplish this (e.g., via the Model of Care and/or SMAC).

*Source: Frequently Asked Questions on Coordinating Medicaid Benefits and Dual Eligible Special Needs Plans Supplemental Benefits, May 27, 2021.

Integration Flexibility : *Benefits and Model of Care*

Medicare Advantage benefit design and care models tend to follow traditional (acute care) Medicare services and provider types. However, a considerable portion of dual eligible individuals use Medicaid services not covered by Medicare, including long-term services and supports and certain behavioral health services.

The FAI has allowed states and MMPs the ability to create a single set of benefits inclusive of both Medicare and Medicaid services, and to develop models of care that incorporate an individual's full medical and non-medical experience.

The D-SNP Model of Care

All D-SNPs must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC serves as the framework for how the D-SNP will meet the needs of its dual eligible enrollees. The MOC includes federally mandated elements such as care coordination, member experience, and quality improvement, and states can add Medicaid-specific requirements to the MOC.

Provision	FAI Flexibility	D-SNP Ability to Deploy Provision	Additional Policy Action Needed
Supplemental Benefits	Through the FAI, states can require MMPs to offer additional benefits beyond standard Medicare and Medicaid benefits.	**States currently can require D-SNPs to offer specific supplemental benefits**, including expanding the availability of a benefit also covered under Medicaid or extending a Medicaid benefit to individuals who would otherwise not qualify for the benefit (e.g., providing home and community-based services to individuals not meeting the state's institutional level of care need). **Supplemental benefit dollars are limited** and vary across D-SNPs based on Star Rating and medical costs. Additionally, **MLRs across the programs are not blended** to account for services that are provided across programs *[see earlier summary of MLR]*.	**Regulatory** *[see previous recommendations related to MLR]*
Model of Care (MOC)	FADs prescribed detailed care model provisions including person-centered care requirements, operation of a transitional care management team, and assessment timeframes.	States **currently can require D-SNPs to address specific provisions in the MOC**. However, **CMS MOC approval (via the NCQA) occurs at the contract level**, while D-SNPs typically operate at the plan ID level, creating potential misalignment in states using multiple D-SNP plans to serve different populations. Additionally, **national MOC requirements are general across all SNP types** (including non-D-SNPs), meaning Medicaid and long-term services and supports needs are not explicitly addressed in a D-SNP MOC unless a state requires it.	**Regulatory/ Guidance** CMS should consider adjusting MOC requirements to include the role of Medicaid in serving D-SNP enrollees. CMS also could require state review of D-SNP MOCs. *[see also earlier policy action regarding contract structure]*

D-SNP MOC requirements are enumerated in the Medicare Managed Care Manual, Chapter 5.

Integration Flexibility : *Member Communications and Customer Service*

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 FAIs allowed states and plans to test new approaches to creating better member experiences including aligning Medicare and Medicaid appeals and grievances processes and timelines.

Provision	FAI Flexibility	D-SNP Ability to Deploy Provision	Additional Policy Action Needed
Enrollee Services	Most FADs set enrollee service standards. For example, all capitated MMPs are required to operate a toll-free call center that must answer at least 80% of calls within 30 seconds and limits the average hold time until meeting a live representative.	**Integrated enrollee services are currently possible in D-SNP programs.** Idaho, for example, requires their D-SNP customer service representatives to be knowledgeable about both Medicare and Medicaid benefits and contract terms. Call centers are a core health plan administrative function that can be integrated across Medicare and Medicaid to support health literacy and improve beneficiaries' experience.	**Guidance** MMCO should educate states on best practices and expectations in aligning customer service experiences for dual eligible individuals. This might be an extension of D-SNP requirements to coordinate with Medicaid. CMS also could require specific enrollee services be integrated as part of core SMAC or MOC, such as a single customer service hotline that "warm transfers" without impact or awareness to the dual eligible individual.
Integrated Member Materials	Capitated FADs require that MMPs provide a single ID card, and integrated member handbook, provider directory, and formulary. Integrated member and marketing materials are approved through a joint review process with the state and CMS.	**D-SNPs can be required to submit member and marketing materials to the state for review**. States can mandate that materials be a single document that integrates Medicare and Medicaid information. However, **states must come into compliance with Medicare regulations and statute**, rather than being able top create an integrated process that reflects state approaches. Additionally, existing standardized Medicare material formats and content do not allow for much tailoring or integration with Medicaid provisions.	**Legislative** Certain provisions related to marketing materials are enumerated in law (Social Security Act §1851(h) and § 1860D-1(b)(1)(B)(vi)). Congress should grant MMCO flexibility to waive these provisions and exercise its BBA-provided authority to create an integrated review process and integrated materials for D-SNPs.

Provision	FAI Flexibility	D-SNP Ability to Deploy Provision	Additional Policy Action Needed
Unified Appeals and Grievances	Dual eligible individuals in MMPs have a single, unified appeals and grievances process with aligned timing/processes and integrated notices, whether the issue is related to Medicare or Medicaid.	At a minimum, **D-SNPs must "coordinate" appeals and grievances**, including offering assistance navigating Medicaid appeals and grievances, regardless of whether the services are covered through Medicaid FFS or managed care. **Exclusively aligned* D-SNPs must have a single, unified appeals and grievance process**. However, **states have limited line-of-sight and understanding of "coordinated" appeals and grievances.** Additionally, states report delaying exclusively aligned enrollment due to being **under-resourced to develop an aligned appeals and grievances process**.	**Guidance** CMS should issue best practices on D-SNP requirements to coordinate appeals and grievances, and state approaches to overseeing appeals and grievances coordination. CMS also could provide additional 1-on-1 technical support to states beyond the resources published to date, specific to the state's appeals and grievances process.

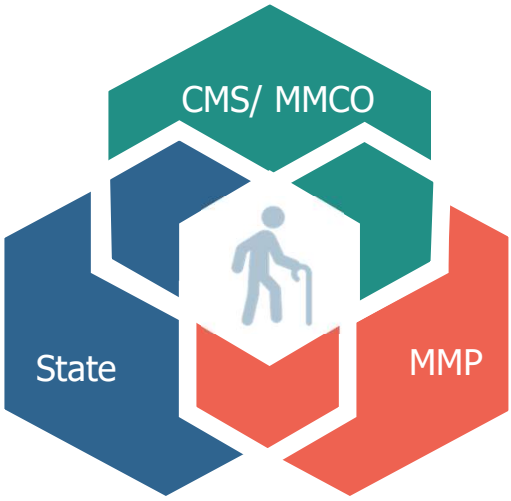
*Exclusively aligned enrollment occurs when a D-SNP only enrolls individuals for which it also has Medicaid risk for long-term services and supports and/or behavioral health.

Integration Flexibility : *Operations and Other Elements*

Managed care plans typically are subject to different and sometimes conflicting requirements from the states in which they operate and CMS. This creates administrative inefficiencies for health plans, as well as barriers for states as they pursue integration with Medicare.

The FAI deployed numerous operational processes to create more seamless oversight of MMPs across the state and CMS, and to ensure dual eligible individuals' needs were reflected in this oversight. Key to this is a contract management team (CMT) between the state and CMS/MMCO, with frequent engagement of the MMP.

The CMT oversees all aspects of the MMP contract and meets regularly with the MMP



Provision	FAI Flexibility	D-SNP Ability to Deploy Provision	Additional Policy Action Needed
Contract Management Team (CMT)	Capitated FADs have a CMT with CMS and state representatives to manage the three-way contracts and enforce MMP compliance. The MFFS FAD employs a joint CMS-State CMT.	**States can partner with CMS through a CMT** to improve collaboration and support oversight. However, **states report that CMS engagement in FAD CMTs offered better oversight and communication than the use of a CMT in D-SNP programs**, for example not having line-of-sight into D-SNP corrective action plans, potentially because MMCO has not exercised its full BBA authority to regulate D-SNPs.	**Regulatory** CMS could require a CMT as part of D-SNP programs; further, MMCO should explore its BBA-provided authority to determine the full scope of CMS' role in a D-SNP CMT.
Enrollee Advisory Committee	All capitated FADs must establish meaningful enrollee input processes that may include enrollee (and caregiver) participation on MMP governing boards or the establishment of an enrollee advisory board.	**States currently can require D-SNP engagement of enrollees and other stakeholders**. For example, some states require D-SNPs to ensure that enrollees and stakeholders are involved in operating committees, especially the quality and appeals and grievance committees.	**Regulatory** CMS could require an enrollee advisory committee as part of D-SNP programs; this committee should be coordinated/ align with the D-SNP's Medicaid member advisory committee required at 42CFR438.110.

Provision	FAI Flexibility	D-SNP Ability to Deploy Provision	Additional Policy Action Needed
Integrated Quality and Quality Improvement	FADs require integrated quality improvement activities across Medicare and Medicaid. The Minnesota demonstration required plans to report one integrated CAHPS survey annually, rather than separate State and CMS CAHPS surveys.	**States can require D-SNPs to develop integrated quality improvement processes**. States may also **align integrated reporting requirements** with Medicare reporting and ask for additional data. However, **states generally must comply with existing Medicare** reporting requirements and timelines. Additionally, **existing Medicare quality measures may not adequately capture the socioeconomic or functional complexity of dual eligible individuals**, leaving states to rely on measures that reflect a broader Medicare population.	**(Sub)Regulatory** CMS should explore its BBA-provided authority to determine opportunities to align quality data collection methods and timelines across Medicare and Medicaid. Certain alignments may be possible through sub-regulatory processes, such as changing measurement timeframes. CMS also should continue to explore quality measures that reflect the unique circumstances of dual eligible individuals. Integrated experiences could be included in these measures.
Network and Network Adequacy	MMPs are subject to unique Medicare and Medicaid network standards. Also, states can require reviews of network adequacy at a cadence more frequent than Medicare Advantage network review.	States **can require D-SNPs to submit their Medicare networks to the state** for review. States **may also require that Medicaid providers have a certain overlap with Medicare providers**, and/or that **D-SNPs contract with specific provider types** beyond those required in Medicare Advantage (E.g., Area Agencies on Aging). States also **can require integrated network materials and websites** if the state comes into compliance with Medicare marketing requirements. However, **Medicare Advantage network adequacy is determined at the contract level** rather than the plan level (D-SNPs typically operate at a plan level).	**Guidance and Process** CMS should issue guidance to states on administering D-SNP programs at the contract level rather than plan ID level. CMS mentioned this approach in the 2023 Notice of Intent to Apply, but states would benefit from guidance on the process and implications. CMS also could work with states to develop integrated provider networks and provider directory templates that are compliant with Medicare marketing requirements.

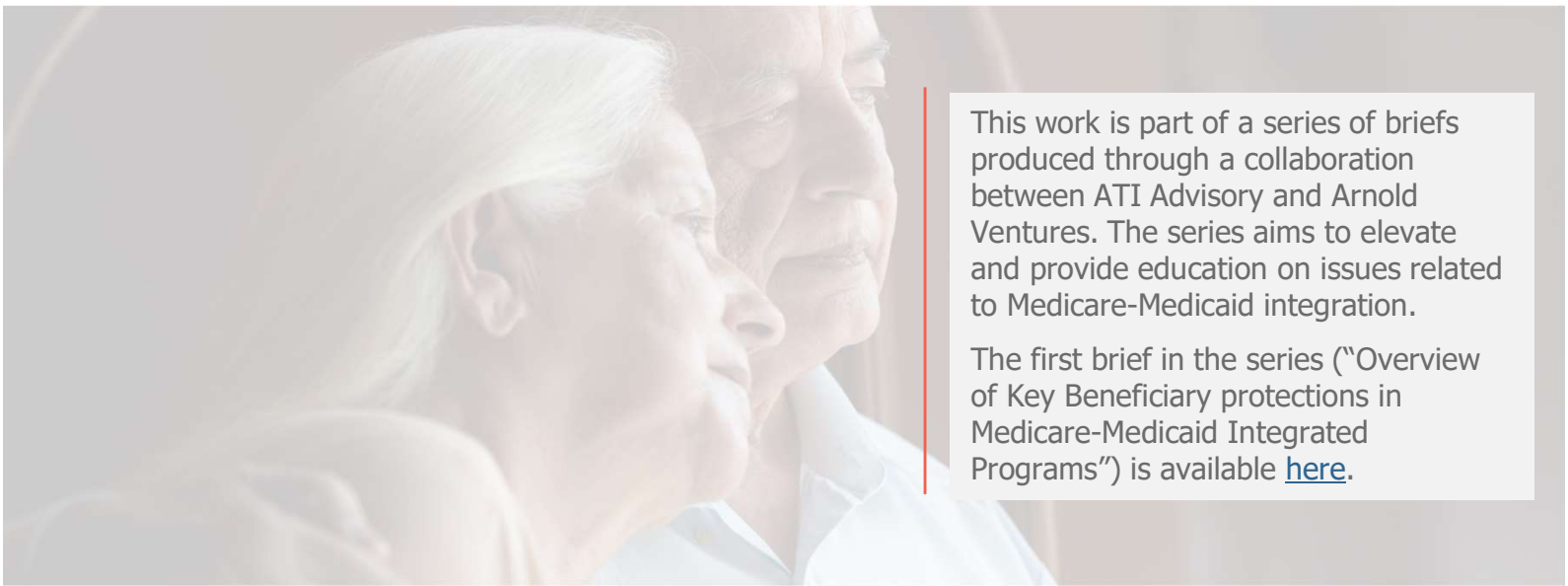
Provision	FAI Authority	D-SNP Authority	Required Policy Action
Joint Readiness Review	CMS and states with capitated FADs performed readiness reviews of MMPs. States required an on-site visit in addition to a review of policies, information infrastructure, staffing, and network adequacy before the plan could be marketed.	The **review process that CMS performs to ensure D-SNPs can operate can be aligned with state processes.** Medicare conducts reviews when Medicare Advantage plans are expanding into new service areas/populations, every three years to conduct a network adequacy assessment, and every one-to-three years to review the clinical Model of Care. Each of these Medicare reviews present on opportunity to align with Medicaid to reduce administrative burden. **However, states must align their processes and timing with Medicare, for example the CMS Medicare Advantage calendar set in regulation**.	**(Sub)Regulatory** Varies by Medicare review type; CMS should explore its BBA-provided authority to determine timing and process alignment for activities related to plan readiness.
Medicare Data Access	States access the Medicare Advantage Prescription Drug (MARx) to obtain real-time plan enrollment data from CMS.	State Medicaid agencies regulating D-SNPs report that they **do not have access to MARx**, but rather they receive enrollment data from the State Medicare Modernization Act (MMA) file. However, the size and difficulty of navigation make the MMA file a less ideal resource than the MARx portal.	**Guidance and Process** CMS should ensure state Medicaid agencies are aware of their access to MARx, ensure this access is sufficient, and issue guidance on how to use the system to promote integration.

Conclusion and Moving Forward

The FAI has demonstrated that meaningfully integrated Medicare and Medicaid programs can improve care experience, outcomes, and cost for dual eligible individuals. While outcomes associated with Medicaid expenditures and utilization are not readily available, evaluations to date have identified potential Medicare cost savings in select FAD programs and improvements in customer experience. However, the FAI has also experienced challenges that have impacted its scalability to additional states and more dual eligible individuals (e.g., overly prescriptive care coordinator staff ratios, inability to use enrollment brokers, the costs to implement the program).

This current analysis demonstrates that a **considerable portion of the beneficial FAI flexibilities are or could be attainable through the D-SNP contract with CMS action,** which would allow the integrated experience accomplished through the FAI to scale to more states.

1 **Clarified State Authority**	States can advance most aspects of the FAI under current D-SNP authority but often do not understand the extent of their authority. CMS should clarify to states how to accomplish FAI provisions in D-SNP programs and could require certain provisions in D-SNP programs.
2 **Unexplored MMCO Authority**	The BBA 2018 provided MMCO with broader authority to promote integration through D-SNPs, but this authority has been minimally used. Congress should clarify the intent of this authority, and CMS should leverage this authority to scale FAI successes to the D-SNP program.
3 **FAI Model Expansion**	Evaluations point to varying levels of FAI success. MMCO should explore whether elements of the FAI meet CMMI spending and quality criteria required to expand FAI provisions into the D-SNP program.
4 **Legislative Change**	States seeking to promote integration often must comply with broad Medicare requirements unrelated to dual eligible individuals, which is burdensome and can create confusing, meaningless experiences for enrollees. Congress should consider the implications of this on system costs and barriers to integration.



This work is part of a series of briefs produced through a collaboration between ATI Advisory and Arnold Ventures. The series aims to elevate and provide education on issues related to Medicare-Medicaid integration.

The first brief in the series ("Overview of Key Beneficiary protections in Medicare-Medicaid Integrated Programs") is available here.

Definitions

Financial Alignment Initiative (FAI). The FAI includes three types of **Financial Alignment Demonstrations (FAD)** to improve alignment and integration of Medicare and Medicaid.

Capitated FAD. The most common FAI demonstration model, currently operating in nine states. These models leverage a three-way contract between a state, CMS, and a **Medicare-Medicaid Health Plan (MMP)**, with comprehensive Medicaid and Medicare benefits, a single set of member materials, and aligned administrative processes.

Managed Fee-for-Service (MFFS) FAD. An agreement between a state and CMS where the state shares in Medicare savings resulting from quality improvement and cost reduction initiatives for dual eligible individuals. Currently a single state (WA) operates this type of program.

Administrative Alignment FAD. Model that tests integration of administration by aligning Medicare and Medicaid policies and procedures. Currently a single state (MN) operates this type of program.

Dual Eligible Special Needs Plan (D-SNP). Medicare Advantage plan that must contract with a State Medicaid Agency and coordinate Medicaid benefits for enrollees. These programs range in their degree of financial and administrative integration.

State Medicaid Agency Contract (SMAC). The contract between a D-SNP and the state in which it operates, detailing D-SNP responsibilities. Also referred to as the MIPPA contract, named after the legislation requiring the contract.