National
MLTSS
Health Plan Association

2025 Policy Proposals to Advance Integrated Care

Today approximately 10 percent of individuals who are dually eligible for both Medicare and Medicaid are enrolled in managed care plans that fully integrate their Medicare and Medicaid coverage. The remaining dually eligible individuals must navigate a complex system of overlapping coverage and disconnected services. Despite significant regulatory and legislative activity around advancing integrated care models at both the state and federal level, many barriers remain.

The National MLTSS Health Plan Association has developed a series of policy proposals to address existing barriers to integration and to advance and grow the enrollment of dually eligible enrollees in an integrated model. **Our proposals are predicated on our steadfast position to build on the existing Dual-Eligible Special Needs Plan (D-SNP) framework and recognize the unique progress of each state towards advancing integrated care**. D-SNPs have been the fundamental, permanent vehicle for delivering integrated care benefits, and CMS continues to emphasize the importance of focusing efforts to iterate upon the existing D-SNP framework to improve care for dually eligible enrollees. **Below, we identify the requisite statutory and regulatory changes needed to advance D-SNPs forward in providing more integrated, holistic, and accessible care for enrollees**.

Our D-SNPs and managed long-term services and supports (MLTSS) health plans with years of experience serving dually eligible enrollees have developed models to support complex populations in a targeted way. **MLTSS Association members have acquired and honed specialized skills to deliver services to the dually eligible population and are well-positioned to continue building upon their existing programs and operations to provide a more person-centered, integrated health care experience for the most vulnerable populations**.

Priority Area	Problem Description	Policy Proposals
 **1) Create a Seamless Experience and Reduce Consumer Burden by Streamlining Enrollment Processes for Integrated Care Products**	At a national level, approximately 10 percent of all dually eligible enrollees are enrolled in an integrated product. Ultimately, individuals must be enrolled in integrated products for the benefits of integration to be realized. Current enrollment processes result in enrollee confusion and fragmentation as enrollees must navigate two separate programs and enrollment processes.	• Promote and expand auto-enrollment flexibilities for dually eligible individuals. • Allow D-SNPs with separate PBPs for full and partial dual eligibles to automatically crosswalk members between these PBPs as their eligibility changes. • Allow Medicare Advantage Organizations to crosswalk members from traditional Medicare Advantage plans into Integrated Plans, or from a Coordination-Only D-SNP into a more integrated plan.
 **2) Increase Stakeholder Awareness of the Benefits of Integration**	A consistent issue with standing up integrated care products and maintaining enrollment is a lack of enrollee and provider understanding. Enrollees may be faced with the possibility of selecting from multiple options for integrated care, or traditional Medicare Fee-For-Service (FFS) and there is no consistent source of information that enables them to weigh their options.	• Develop educational tools for stakeholders on the value of integrated care. • Update Medicare Plan Finder to include information on integrated care products.
 **3) Advance State Capacity to Operate Integrated Care Products**	One factor that contributes to a lack of state adoption of integrated care products is their administrative complexity. This complexity is further exacerbated by limited staff expertise of the Medicare program within applicable State agencies.	• Educate states that do not have Medicaid managed care on the option to implement capitated D-SNPs as a glidepath to managed care. • Better align Medicare and Medicaid contracting deadlines. • Educate states on the necessity of considering Medicare expertise when making decisions that impact a state's integrated care landscape.

Priority Area	Problem Description	Policy Proposals
 **4) Simplify State Options by Creating an Even Playing Field for Integrated Care Products**	Various integrated products are regulated under different statutory authorities and contain variations in basic programmatic features such as payment, enrollment, and marketing. These differences lead to unintended incentives for states, plans, and providers to operate one integrated care product over the other despite serving the same general population.	• Uniformly apply frailty adjuster to all highly integrated products.
 **5) Enhance Ability of Integrated Care Products to Address Members' Complex Medical and Non-Medical Needs**	Dually eligible enrollees are much more likely than non-dually eligible Medicare enrollees to have significant health-related social needs (HRSNs) such as unstable housing, food insecurity or issues with transportation, and obtaining and seeking health care. Further, nearly half of dually eligible enrollees use long-term services and supports (LTSS) (49%). Integrated care products need tools to target additional services to address these complex and health-related social needs to improve dually eligible enrollees' health status and help with management of chronic conditions.	• Allow D-SNPs additional flexibilities to meet the needs of complex populations, including through supplemental benefits.
 **6) Promote Access to Integrated Care Products for Partial Dually Eligible Enrollees**	While partial duals experience similar social, functional, and medical needs as full benefit dual eligible enrollees, they are subject to gaps in coverage and can have less access to integrated care products. All partial duals should continue to have access to D-SNPs and other managed care products to ensure they can benefit from the enhanced care coordination and connections to community-based benefits and supports these products provide.	• Create standard definitions for dual eligibility categories, aligning categories across states. Exclude partial duals from counting towards D-SNP lookalike thresholds in states where partial dually eligible individuals cannot enroll in D-SNPs.

Priority Area	Problem Description	Policy Proposals
 **7) Improve Care Coordination for Dually Eligible Enrollees by Supporting MLTSS Plan Access to Medicare Data and Streamlining Data Collection**	While MLTSS plans and providers gain valuable insights into dual eligibles' health care needs and quality of life through LTSS interventions, fundamental system constraints limit their access to primary care provider and other medical utilization data. Improving MLTSS plans' access to Medicare data will allow them to better respond to and coordinate their medical and non-medical needs.	• Develop a database with Medicare data for all dually eligible enrollees that MLTSS plans can access for their enrollees. • Provide access to the Health Plan Management System (HPMS), including the Complaint Tracking Module (CTM), as well as the Medicare Advantage/ Prescription Drug System (MARx), to all states with D-SNPs, beyond those with exclusively aligned enrollment. • Adopt integrated Medicare-Medicaid data reporting

Below we offer additional details and technical comments on each of the Association's proposals. Please contact Mary Kaschak at mkaschak@mltss.org with any questions regarding these policy proposals.

1) Create a Seamless Experience and Reduce Consumer Burden by Streamlining Enrollment Processes for Integrated Care Products

<u>Policy Proposal #1:</u> Promote and expand auto-enrollment flexibilities for dually eligible individuals.

General Description	Most dually eligible individuals (73 percent) are eligible for full Medicaid benefits, meaning they can receive the full range of state-covered services in addition to what Medicare covers and would benefit from the care coordination that Dual Eligible Special Needs Plans (D-SNPs) offer. However, despite D-SNPs' ability to meet the needs of dually eligible individuals, enrollment has remained low, with less than half of all dually eligible individuals enrolled in a D-SNP.[1] Historically, in response to low participation in integrated Medicare–Medicaid models, CMS has leveraged different forms of auto-enrollment coupled with beneficiary protections to improve enrollment. This was demonstrated most clearly in the Financial Alignment Initiative where auto-enrollment was used to sustain enrollment numbers in Medicare-Medicaid plans (MMPs). We propose to build off the lessons learned from the MMP demonstration's use of auto-enrollment to promote and expand state flexibilities in the following ways: **Provide the state option to expand auto-enrollment authority to facilitate aligned enrollment, including based on an individual's Medicaid MCO enrollment choice/assignment**: For full benefit dually eligible individuals enrolled in a Medicaid MCO, who are also enrolled in Medicare FFS, **grant states additional auto-enrollment authority to automatically align dually eligible individuals to an affiliated integrated D-SNPs** in accordance with federal guidelines for beneficiary notice and protections. **Promote the use of existing authority to facilitate aligned enrollment based on an individual's Medicare D-SNP enrollment choice:** For full benefit dually eligible individuals who elect to receive Medicare coverage through a D-SNP, **encourage states to leverage state Medicaid manage care enrollment authority at 42 CFR 438.54 to auto-enroll these individuals into an affiliated Medicaid MCO when available.**
Specific Mechanism of Change	**To achieve aligned enrollment, the MLTSS Association supports giving states the flexibility to implement the auto-enrollment policies that work best for them. Advancing integrated care will look different across states and do not wish to be prescriptive in our approach.** **Examples of Specific Mechanisms:** • **When Medicaid Leads:** States currently have flexibility to auto-enroll full-benefit dually eligible individuals into an affiliated D-SNP during the Initial Coverage Election Period (ICEP). Expand auto-enrollment authority to permit auto-enrollment of dually eligible individuals currently enrolled in traditional (FFS) Medicare into the Medicaid MCO's parent company's D-SNP.

[1] https://www.kff.org/medicare/10-things-to-know-about-medicare-advantage-dual-eligible-special-needs-plans-d-snps

	• **When Medicare Leads:** States already have the flexibility to allow auto-enrollment of full-benefit dually eligible individuals into a Medicaid MCO affiliated with their D-SNP election. Encourage this process through targeted education, outreach, and technical assistance to ensure states can operationalize these flexibilities effectively to achieve aligned enrollment, while incorporating required notice, opt-out rights, and continuity-of-care protections. For any auto-enrollment approach, provide guidance to states and health plans highlighting best practices for the use of enrollment authorities, **including adequate education for members and health plans** and timely notifications. Emphasize the need for education and technical assistance to states about the alignment of Medicaid enrollment periods and effective dates with those in Medicare to facilitate a seamless transition and prevent delays in covered services. The MLTSS Association **supports aligned enrollment into integrated care plans** and **does not support one auto-enrollment pathway over another**.
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	This auto-enrollment proposal includes robust guardrails to ensure individuals are protected, including: **Under any auto-enrollment scenario:** Enrollees would have a 60-90 day opt-out period. If an enrollee has actively chosen a product (i.e., standalone D-SNP, HIDE, or FIDE), they should not be moved to another option through passive enrollment to preserve enrollee choice. The consumer protection floor should follow MMP guidelines[2]. **When Medicaid leads:** HIDE-SNPs/FIDE-SNPs must notify enrollees 60 days prior to effective enrollment date and follow continuity of care provisions for 6 months. Notices must include information on other D-SNP plan options available to them and provide a direct link to the Medicare Plan Finder for their county, filtered to show D-SNPs they are eligible for. Plans must have 3+ Stars in order to be eligible for passive enrollment; or have no Star Rating if the plan is new and/or has low enrollment. There must be at least two D-SNPs in a service area to have auto-enrollment. Automatic enrollment into HIDE and FIDE SNPs would apply to any HIDE SNP and FIDE SNP entities that have a Medicaid contract which covers, at minimum, a comprehensive set of long-term services and supports as well as home and community-based services with reasonable state-specified service exclusions and carve-outs. New D-SNP enrollees should receive a transition/temporary supply of eligible Part D drugs (generally at least a one-month supply where applicable) so beneficiaries do not have a gap in therapy on their effective date. Plans should send the CMS-approved

[2] Each state participating in the Financial Alignment Initiative was required to develop a Memorandum of Understanding (MOU) with CMS to establish the parameters of the demonstration, including beneficiary protections.

	written transition notice to the enrollee (and prescriber when applicable) within 3 business days For beneficiaries who are mid-course of treatment at the time they switch plans, D-SNPs must honor existing prior authorizations and provide a minimum 90-day transition period during which the new plan generally may not impose a new prior authorization or interrupt the active course of treatment. This is an existing regulatory requirement. **When Medicare leads:** States with Medicaid plan selection lock-in policies should evaluate their impact on beneficiary choice in the context of this authority and the monthly special enrollment periods. For beneficiaries who are mid-course of treatment at the time they switch plans, Medicaid managed care plans must honor existing prior authorizations and provide a minimum 90-day transition period during which the new plan generally may not impose a new prior authorization or interrupt the active course of treatment.

<u>Policy Proposal #2:</u> Allow Medicare Advantage Organizations to crosswalk members from traditional Medicare Advantage plans into Integrated Plans, or from a Coordination-Only D-SNP into a more integrated plan.

General Description	Allow Medicare Advantage Organizations (MAOs) to crosswalk members from traditional Medicare Advantage plans into Integrated Plans, or from a Coordination-Only D-SNP into a more integrated plan. And allow MAOs to crosswalk D-SNP enrollees across product types, with the same or higher level of integration, under the same parent organization (i.e. crosswalking members from an HMO D-SNP into a PPO D-SNP).
Specific Mechanism of Change	Rulemaking required; CMS would need to amend 42 CFR § 422.530 to allow these additional cross-walking flexibilities.
Funding Mechanism	This proposal does not require additional Congressional appropriations.
Consumer Protections/Guardrails	Enrollees would have a 60-90 day opt-out period, with the opportunity to remain in their current plan. Dually eligible individuals could only be cross-walked into a D-SNP with a Star Rating of 3 Stars or higher.

<u>Policy Proposal #3</u>: Allow D-SNPs with separate PBPs for full and partial dual eligibles to automatically crosswalk members between these PBPs as their eligibility changes.

General Description	Allow D-SNPs with separate PBPs for full and partial dual eligibles to automatically crosswalk members between these PBPs as their eligibility changes.
Specific Mechanism of Change	Rulemaking required; CMS would need to amend 42 CFR § 422.530 to allow these additional crosswalking flexibilities.
Funding Mechanism	This proposal does not require additional Congressional appropriations.

Consumer Protections/Guardrails	This change would ensure that dually eligible individuals are consistently enrolled in the D-SNP plan associated with their dual eligibility level. This change would also minimize churn and member disruption.

2) Increase Stakeholder Awareness of the Benefits of Integration

<u>Policy Proposal #1:</u> Develop national and state-level tools for enrollees and other stakeholders to help enrollees navigate the integrated care market.

General Description	Require CMS, MMCO, and the Administration for Community Living (ACL), in collaboration with other stakeholders, to develop educational materials on the benefits of integrated care. These educational materials should be developed for different stakeholder groups, including enrollees, brokers, providers, COAs/CBOs, states, and members of Congress.
Specific Mechanism of Change	CMS, MMCO, and ACL, in collaboration with other stakeholders, would be required to develop educational materials to be used on the national level on the benefits of integrated care with the goal of increasing enrollee awareness and knowledge of integrated care products. The process of developing materials should include the opportunity for external stakeholder input. These tools may include online navigation platforms to assist enrollees in navigating their integrated care options. For example, the National Council on Aging, in collaboration with The SCAN Foundation and ACL, created an online decision support tool to help enrollees in Ohio, California, and Michigan navigate their integrated care options.
Funding Mechanism	Appropriation from Congress to fund CMS, MMCO, and ACL to develop integration education materials and tools.
Consumer Protections/Guardrails	The materials and guidance could be required to be impartial to any particular coverage arrangement for a dually eligible enrollee.

<u>Policy Proposal #2:</u> Update Medicare Plan Finder to include information on integrated care products.

General Description	Require CMS to update Medicare Plan Finder (MPF) to include new functionality and information on integrated care products. .
Specific Mechanism of Change	CMS should continue to make planned improvements to Medicare Plan Finder, and consider future updates, that make information on integrated care products more accessible to enrollees, including information on State Health Insurance Assistance Programs (SHIPs).
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	Ensuring that correct information about integrated plans is displayed on Medicare Plan Finder will assist consumers in making informed decisions about their healthcare coverage.

3) Advance State Capacity to Operate Care Products

Policy Proposal #1: Educate states that do not have Medicaid managed care on the option to implement capitated D-SNPs as a glidepath to managed care.

General Description	Educate states that do not have Medicaid managed care on the option to implement capitated D-SNPs. Under this model, states can directly capitate specified Medicaid services into their existing State Medicaid Agency Contracts (SMACs) rather than using a separate Medicaid contract to cover Medicaid services for dual eligible individuals enrolled in the D-SNP. Capitated D-SNPs can serve as a glide-path to statewide Medicaid managed care and/or MLTSS.
Specific Mechanism of Change	States can currently elect to include selected Medicaid services for dually eligible individuals in their SMACs and provide a PMPM for these services outside of the PMPM the D-SNP receives to cover Medicare services. CMS can promote the adoption of this model by states that do not have Medicaid managed care. This model may serve as an initial step towards managed care in states that have FFS Medicaid programs.
Funding Mechanism	Under this model, states would provide an additional PMPM for Medicaid services covered under the capitated D-SNP.
Consumer Protections/Guardrails	The capitated D-SNP model provides more robust coverage for dually eligible individuals under a single plan in states that do not have managed care infrastructure.

Policy Proposal #2: Better align Medicare and Medicaid contracting deadlines.

General Description	SMACs are contracts between states and Medicare Advantage Organizations operating D-SNPs. SMACs must be developed and executed on an annual basis, a process that requires significant coordination between state Medicaid agencies and health plans. D-SNPs must also adhere to annual MA contracting processes in accordance with Federal requirements. Often, these processes are not aligned, causing a range of operational, regulatory, and programmatic issues for D-SNPs. In response to these challenges, the MLTSS Association has published Key Recommendations to Address SMAC Challenges, as well as a Recommended SMAC Development Timeline. These educational resources are intended to support states and plans as they work together to develop their integrated care offerings. CMS can support better alignment of Medicare and Medicaid contracting deadlines through additional outreach and education to states.
Specific Mechanism of Change	CMS, through MMCO and/or ICRC, could release guidance to states about aligning Medicaid and Medicare contracting deadlines. This guidance can include educational materials to help states understand the tensions between Medicare and Medicaid contracting deadlines.
Funding Mechanism	This proposal does not require additional Congressional appropriations.

Consumer Protections/Guardrails	The alignment of Medicare and Medicaid contracting deadlines will facilitate states' and health plans' ability to provide a seamless member experience for dually eligible individuals enrolled in integrated plans.

<u>Policy Proposal #3:</u> Educate states on the necessity of considering Medicare expertise when making decisions that impact a state's integrated care landscape.

General Description	Educate states on the necessity of considering Medicare expertise when making decisions that impact a state's integrated care landscape.
Specific Mechanism of Change	Decisions made by state Medicaid agencies, including Medicaid managed care procurements, impact the integrated care options available in the state. CMS, via ICRC and/or MMCO, can provide education to states on how to consider Medicare expertise within the context of the state's integrated care landscape.
Funding Mechanism	This proposal does not require additional Congressional appropriations.
Consumer Protections/Guardrails	The educational materials would be required to be impartial to any particular coverage arrangement for a dually eligible enrollee.

4) Simplify State Options by Creating an Even Playing Field for Integrated Care Products

<u>Policy Proposal #1:</u> Uniformly apply frailty adjuster to all highly integrated products.

General Description	Apply the frailty adjustment for all highly integrated products, to also include HIDE SNPs. Currently, fully integrated D-SNPs that have a similar average level of frailty as the PACE program are eligible to receive a frailty adjustment payment. The Medicare Health Outcomes Survey (HOS) is used to determine if a D-SNP reaches the required level of frailty. However, other mechanisms may be more appropriate to make this frailty determination and should be explored.
Specific Mechanism of Change	Rulemaking required; CMS would need to amend 42 CFR § 422.308(c)(4) to make these changes. The distinction between FIDE SNPs and other SNP plan types almost uniformly stems from state policy decisions in the management of their Medicaid services, and not demographic or acuity makeup. If states choose not to "carve in" LTSS and behavioral health (BH) services into their Medicaid managed care programs, then no plans operating in that state will achieve FIDE SNP status. Despite this, the enrollee demographic and acuity scores between across D-SNPs are very similar. Thus, the problem that the frailty adjuster was intended to solve for – disproportionate financial impact of high acuity frail enrollees – is faced by more plan types than just PACE and FIDE SNPs. A universal frailty adjuster for highly integrated products would more appropriately align predicted with actual costs for the populations served by integrated plans, support actuarial soundness, and provide financial stability for plans to reinvest in integrated care models and sustainable growth.
Funding Mechanism	This change would not require additional appropriations but may result in additional Medicare expenditures for Part A and B rates.
Consumer Protections/Guardrails	Not applicable

5) Enhance Ability of Integrated Care Products to Address Complex and Health-Related Social Needs of Dually Eligible Enrollees

<u>Policy Proposal #1:</u> Allow D-SNPs additional flexibilities to meet the needs of complex populations, including through supplemental benefits.

General Description	Medicare beneficiaries, particularly those with low socio-economic status and chronic health conditions, often face significant challenges. The VBID model has provided MA plans with flexibilities to offer services (including special supplemental benefits) to enrollees eligible for low-income subsidies, those dually eligible for Medicaid and Medicare, as well as those with chronic conditions. Due to the recent termination of the VBID model, the existing regulatory authorities associated with supplemental benefits will limit services and leave our most vulnerable, complex populations with substantial barriers to maintaining their health. To best serve these vulnerable members, D-SNPs will need additional flexibilities to meet the needs of these populations, including through supplemental benefits. Additionally, allowing health plans to provide supplemental benefits during the grace period will ensure that individuals do not experience a delay or loss in supplemental benefits during redeterminations.
Specific Mechanism of Change	In 2018, CMS used its statutory authority to expand supplemental benefit flexibility. During President Trump's first term there were several expansions of benefit flexibility, including through the 2019 Call Letter, an HPMS Memo dated April 27, 2018, and the 2019 Final Rule all of which included an interpretation of the MA uniformity requirement that will allow for more flexibility in benefit design for MA enrollees. There are opportunities for expanding supplemental benefit flexibilities under various sections of the Act, including §422.100(c)(2)(ii), §422.100(d), and §423.104(b), and we encourage CMS to utilize its authority to maintain and improve the health of Medicare beneficiaries as it did in 2018. Specifically, CMS could issue bid guidance that would allow MA plans to offer a broader set of supplemental benefits, primarily and non-primarily health-related, to MA beneficiaries eligible for the Low-Income Subsidy (LIS) program.
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	Expansion of supplemental benefit flexibilities should be accompanied by government investments in tools to support enrollees in navigating and understanding the benefits that are available to them (e.g., supplemental benefits should be clearly displayed on Medicare Plan Finder, SHIP counselors should receive information on benefits as soon as possible as well as additional funding to support training).

6) Promote Access to Integrated Care Products for Partial Dually Eligible Enrollees

***Key Context**: Partial dually eligible enrollees (partial duals) are eligible for Medicare assistance with certain costs (e.g., premiums and costs-sharing) through Medicare Savings Programs (MSPs) but are not eligible for full Medicaid benefits (e.g., LTSS or BH services) due to a higher income or level of assets.*

Research has shown partial duals to be very similar to full benefit duals. They express similar social, functional, and medical needs, as well as comparable healthcare utilization patterns. Partial duals are also subject to high rates of eligibility churn.

However, partial duals are often excluded from integrated care policy efforts, in part due to the lack of coverage for full Medicaid benefits. For example, certain states exclude partial duals from enrolling in advanced integrated care plans. This is in spite of partial duals benefiting from D-SNP enrollment, with research showing D-SNP-enrolled partial duals to exhibit higher rates of PCP visits and lower rates of hospitalizations, readmissions, emergency department visits, and skilled nursing facility admissions compared to partial duals enrolled in Medicare FFS. Furthermore, partial duals can often shift to full dual status, and already being enrolled in an integrated care model can ease transitions and minimize gaps in care.

Our proposals below ensure partial duals can access integrated care models and the benefits they provide.

Policy Proposal #1: Exclude partial duals from counting towards D-SNP lookalike thresholds in states where partial dually eligible individuals cannot enroll in D-SNPs.

General Description	Exclude partial duals from counting towards D-SNP lookalike thresholds in states where partial dually eligible individuals cannot enroll in D-SNPs.
Specific Mechanism of Change	Rulemaking required; CMS should amend 42 CFR § 422.514(d) to exclude partial dually eligible individuals from the D-SNP lookalike calculation in states where partial dually eligible individuals are not permitted to enroll in D-SNPs.
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	Excluding partial duals from the lookalike calculation in states where they cannot enroll in D-SNPs will promote member choice in their Medicare options.

Policy Proposal #2: Create standard definitions for dual eligibility categories, aligning categories across states.

General Description	Align standard definition categories for dual eligibility across states
Specific Mechanism of Change	State defined criteria for partial dual eligibility categories do not always align with CMS' categories, leading to enrollment errors and enrollee confusion. CMS can work with states to define a universal criterion for partial and full duals. CMS should require states to develop an eligibility crosswalk that aligns with data that the state reports to CMS. State portals, in contrast, often report eligibility categories that do not align with these reports.

Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	Enrollees' eligibility for certain services and programs should not change as a result of the standardized eligibility categories (i.e., there should be no reduction in access to services as a result of the eligibility category changes).

7) Improve Care Coordination for Dually Eligible Enrollees by Supporting MLTSS Plan Access to Medicare Data

<u>Policy Proposal #1:</u> Develop a database with Medicare data for all dually eligible enrollees that MLTSS plans can access for their enrollees.

General Description	Establish a database with Medicare data for all dually eligible enrollees that Medicaid Managed Care plans could access for their enrollees.
Specific Mechanism of Change	CMS would be responsible for establishing a database with Medicare data for all dually eligible enrollees. The database would include the enrollees' Medicare program Enrollment, Medicare contract number (if applicable), and Medicare claims data in the future.
Funding Mechanism	This proposal does not require additional Congressional appropriation.
Consumer Protections/Guardrails	Medicaid Managed Care plans would only be able to access data for their enrollees for whom they can verify enrollment in their plan using key identifiers (e.g., plan has an enrollee's date of birth and Social Security Number or Medicare Beneficiary Identifier).

<u>Policy Proposal #2:</u> Enhance State Access to HPMS and CTM Data for D-SNP Oversight.

General Description	Provide access to the Health Plan Management System (HPMS), including the Complaint Tracking Module (CTM), as well as the Medicare Advantage/ Prescription Drug System (MARx), to all states with D-SNPs, beyond those with exclusively aligned enrollment. States participating in the MMP demonstration were afforded access to HPMS, along with MARx 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. This access enabled states to coordinate eligibility, review marketing materials, and monitor complaints in real time. Currently, states with D-SNPs do not have the same level of access.
Specific Mechanism of Change	CMS would provide access to HPMS and CTM data to states through secure accounts. CMS would also provide training, data use agreements, and implement security protocols to ensure HIPAA compliance and oversight. CMS would be responsible for maintaining and monitoring these systems to ensure their usability for states
Funding Mechanism	This proposal does not require additional Congressional appropriations.
Consumer Protections/Guardrails	CMS would be responsible for ensuring data protection and security to ensure compliance with HIPAA requirements.

<u>Policy Proposal #3:</u> Adopt integrated Medicare-Medicaid data reporting.

General Description	CMS should require D-SNPs to adopt integrated Medicare-Medicaid quality reporting, aligning measures and reporting processes with state Medicaid programs to the greatest extent possible. During the MMP demonstration, CMS and states collaborated to align reporting requirements across Medicare and Medicaid, including HEDIS, HOS, CAHPS, and quality improvement activities. This integrated approach allowed for a holistic view of care, enabling states and CMS to monitor plan performance, identify gaps in care coordination, and improve outcomes for dual-eligible beneficiaries. Currently, D-SNPs report primarily to Medicare, with limited alignment to state Medicaid metrics, leaving gaps in visibility into full-spectrum care.
Specific Mechanism of Change	CMS would standardize quality measures across Medicare and Medicaid, including HEDIS, HOS, CAHPS. CMS would also align quality data collection methods and timelines across the programs, including opportunities to measure quality at the plan level. CMS would also consider how these existing tools can be tailored to accommodate the unique needs of the dually eligible population.
Funding Mechanism	Integrated quality reporting would largely leverage existing CMS infrastructure and not incur additional costs. There may be additional costs to CMS associated with extensive system upgrades or new survey tools tailored for dually eligible individuals.
Consumer Protections/Guardrails	CMS would be responsible for ensuring data protection and security to ensure compliance with HIPAA requirements. CMS would be responsible for aggregating and sharing the data collected in order to monitor and improve care delivery for dually eligible individuals.

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