mLTSS MCE Enrollment –

See Section 5 of the Scope of work.

What Can MCEs do:

At the discretion of the State (FSSA), MCEs can market its plan to eligible mLTSS Medicaid recipients (covered persons or members living at home or in congregate care settings) via digital, mail and mass media advertising such as digital media, radio, television and billboards. FSSA requires gender and category neutral marketing (i.e. not just seeking healthy or male or female members) and encourages community-oriented marketing such as participation in community health fairs. Tokens or gifts of nominal value may be distributed at such events to potential members, so long as the MCE acts in compliance with all federal and state regulations and guidance regarding inducements in the Medicare and Medicaid programs.

Upon request by member(s) or potential member(s), marketing materials shall be available in the member's preferred language and/or format. Marketing materials and plans shall be neutrally designed to reach a broad distribution of potential members across age and gender categories.

MCEs must market to all areas of the state; regional or urban v. rural targeting is not permitted.

What MCEs cannot do:

MCEs are not allowed to coerce a potential member or their legal representative into choosing a certain MCE.

They also cannot individually target potential members (i.e. healthy people at the expense of high acuity people).

Finally, MCEs are prohibited from doing the following (list is not exhaustive):

- Handing out materials and/or activities that mislead, confuse or defraud or that are unfair or engage in deceptive practices or that otherwise violate federal or state consumer protection laws or regulations. This includes materials which mislead or falsely describe covered or available services, membership or availability of network providers, and qualifications and skills of network providers.
- Engaging in overly aggressive solicitation, such as repeated telephoning or continued recruitment after an offer for enrollment is declined, or similar techniques;
- Providing offers of substantial gifts or material or financial gain as incentives to enroll;
- Engaging in directly or indirectly, door-to-door, telephone, or other cold-call marketing activities;
- Making assertions or statements (whether oral or written) that the enrollee must enroll with the MCE in order to obtain benefits or in order not to lose benefits;
- Making assertions or statements (whether written or oral) that the MCE is endorsed by CMS, the federal or state government or similar entity; and
- Disenrolling or limiting services merely due to the resident's heath care needs or utilization level(s).

How does a residents choose an MCE (section 5, and 2.1):

Members will have the opportunity to select or change their MCE at the following intervals:

- Within sixty (60) days of starting coverage;
    - This will be whenever the mLTSS implementation goes live (~ 7/1/24) and/or when the potential member enters the mLTSS managed care system.
- At any time the member's Medicare and Medicaid plans become unaligned;

- Once per calendar year for any reason;
- At any time using the **just cause** process (defined below)
- During the Medicare open enrollment window (mid-October-mid December) to be effective the following calendar year.

Just-cause reasons include, but not are limited to, the following:

- Receiving poor quality of care;
- Failure to provide covered services;
- Failure of the MCE to comply with established standards of medical care administration;
- Lack of access to providers experienced in dealing with the member's health care needs;
- Significant language or cultural barriers;
- Corrective action levied against the MCE by the office;
- Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
- A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
- Lack of access to medically necessary services covered under the MCE's contract with the State;
- A service is not covered by the MCE for moral or religious objections, as described in Section 7.8.2(scope of work)
- Related services are required to be performed at the same time and not all related services are available within the MCE's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
- The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE; or
- Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

Other Requirements of the MCE:

MCE must assure that each member has a PCP, either at enrollment or within 30 days of enrollment. Member preference should be followed where possible.

MCE must provide welcome materials to each member, which will include a welcome letter and handbook, a member ID Card, and MCE program and contact information.

At the time of enrollment, MCE must complete a Comprehensive Health Needs Assessment within thirty (30) days of the implementation date for its members. See section 4.6-8 of the Scope of Work for rules around the initial and ongoing assessment process. Care Manager/Care Management requirements are found in section 4.9 of the Scope of Work; care coordinator to member ratio shall not exceed 1:50 (see sec. 4.15); service coordinator to member ratio shall not exceed 1:50 (see sec. 4.16).

Claims/payment matters, including services provided at the time of enrollment and coordination of benefits between Medicare and Medicaid (and other third-party sources) are found in the Scope of Work at sections 2.1, 2.7.7, 9.7, 9.9, among other sections.