



# SNP Alliance

A National Nonprofit Leadership Organization

*The National Voice for Special Needs and Medicare-Medicaid Plans*

**Date:** April 12, 2018

**To:** [MMCOCapsmodel@cms.hhs.gov](mailto:MMCOCapsmodel@cms.hhs.gov).

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**Re:** Comments on Section 50311: MMCO Request for Stakeholder Input: Implementing the Dual Eligible Special Needs Plans (D-SNPs) Provisions of the Bipartisan Budget Act of 2018 (Public Law No. 115-123)

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The SNP Alliance appreciates the opportunity to make the following recommendations in response to the Request for Stakeholder Input Implementing the Dual Eligible Special Needs Plans (D-SNPs) Provisions of the Bipartisan Budget Act of 2018 (Public Law N. 115-123).

The SNP Alliance is a national leadership organization dedicated to improving total quality and cost performance through specialized managed care and advancing integration of health care for individuals who are dually eligible for Medicare and Medicaid. As an invitation only leadership group, our membership includes representation from many of the nation's leading health plan organizations. We represent 24 organizations of special needs plans and Medicare/Medicaid plans serving 1.5 million enrollees. Our members serve over 50 percent of Special Needs Plans (SNPs) enrollees with representation from all SNP types, including those serving: (1) beneficiaries dually eligible for Medicare

and Medicaid benefits (D-SNPs); (2) those diagnosed with a severe or disabling chronic condition (C-SNPs); and (3) those living in or eligible for nursing home care (I-SNPs). About three-quarters of the Alliance's members operate fully-integrated, dual-eligible SNPs (FIDESNPs) or plans in the CMS Financial Alignment demonstration (MMPs).

The SNP Alliance has sought permanent status for all SNPs including D-SNPs since their inception in 2003 and has been a strong advocate for the integration of Medicare and Medicaid in order to optimize service delivery and health outcomes for dually eligible beneficiaries and we are excited to reach the milestone in the development of integrated Medicare and Medicaid programs that this new statute will enable. In addition to these comments, we have attached our long-range vision statement for integrated care to this submission. We look forward to continued conversations and collaboration with the MMCO as we all work to implement the new provisions.

## **SECTION I. INTEGRATION STANDARDS**

### **A. Guiding Principles and Goals for Development of Integration Standards**

The Medicare Medicaid Coordination Office (MMCO) should consider the following guiding principles and goals when establishing new guidance and regulations for integration of Medicare and Medicaid:

1. Emphasize meaningful movement forward to “increase integration” (in order to fulfill both statutory requirements and congressional expectations).
2. Accommodate flexibility for reasonable accommodation of state design differences (such as state-imposed variations in Managed Long Term Care Services and Supports (MLTSS) and Behavioral Health (BH) coverage, carve-outs and capitations).
3. Do not penalize plans for circumstances out of their control (such as state design decisions or limitations on state resources needed to support integrated models).
4. Focus integration standards on areas that improve beneficiary experience and coordination of care delivery across settings and over time.
5. Reduce complexity for beneficiaries and minimize plan and state administrative burden where possible by building, refining or aligning existing processes.

### **B. Approach**

1. The MMCO should adopt a broad interpretation of the statutory language “to the extent permitted under state law”: To the extent certain integration features are not prohibited under state statute, administrative or regulatory processes, CMS would assume it is “permitted” and within the purview of a state to determine which integration pathway to apply.
2. State and CMS Roles Should:
  - a. Use joint communications process between plans, state and CMS based on experience with demonstrations as extended to D-SNPs and states as noted under Level One below.
  - b. Include consultation and discussion with states and plans prior to any final determinations to avoid misunderstandings of plan status and state policies.
  - c. Consider whether any lack of compliance relates to state actions versus is within a plan's control.
  - d. Consider a state's overall goals and plan for integrated plan coverage and implementation to avoid disruptions and continuity of care.
  - e. Utilize a consistent approach to compliance applied across plans within a given state.

3. Current Minimum Medicare Improvements for Patients and Providers Act (MIPPA) Requirements (provided for convenient reference): All D-SNP State Medicaid Agency Contracts (SMACs) must already meet the following current minimum MIPPA requirements:
  - a. Must describe plans process for providing or arranging for benefits and must specify how benefits are integrated/coordinated.
  - b. Specify categories of duals to be enrolled including specific subsets.
  - c. Describe Medicaid benefits offered in the State Plan as well as health plan benefit design and administration and responsibility for providing or arranging for covered benefits.
  - d. Cost sharing: DSNPs cannot impose cost sharing that exceeds amounts that would have been charged if not enrolled in the DSNP and must meet Maximum Out-of-Pocket (MOOP) cost requirements.
  - e. Identification and sharing of information about Medicaid provider participation to include them in the SNP directory
  - f. Medicaid eligibility verification process description based on real time data from the State
  - g. The DSNP service area consistent with SMAC approved area
  - h. The contracting period (must be one full contract year (CY)). SMAC submitted to CMS by July 1 each year.

### **C. Suggested Integration Standards and Features:**

#### **1. Build on Existing MIPPA Requirements**

We propose that MMCO consider building on these current MIPPA contract provisions to increase movement toward integration and strengthen coordination through the addition of key minimum integration standards such that *all plans, regardless of integration continuum status, level of enrollment alignment or level of Medicaid benefits offered*, would be permitted to use these strategies based on the needs of the state and the specific duals population served. To accomplish this, MMCO could provide a list of integration standards options for plans and states to address in their MIPPA contracts to meet this basic but improved level of integration. These standards would focus on increased coordination between Medicare and Medicaid services regardless of plan benefits and delivery sources. CMS might designate some provisions as minimum requirements while others could be chosen from a range of options or alternatives based on decisions made by states and health plans through their MIPPA contracting process. In addition, MMCO could include additional provisions, features, incentives and reductions of administrative burden for plans meeting higher levels of integration as suggested further below.

#### **2. Option One**

As provided by paragraph (D)(i)(I), MMCO shall establish a minimum level of standards to qualify to meet this option. We recommend that this option be available to all D-SNPs regardless of level of enrollment alignment and Medicaid benefits offered, including plans coordinating (not directly delivering) MLTSS and/or BH services for members in FFS or unaligned members and/or for plans serving partial dual beneficiaries. While the statute outlines several possible integration criteria for inclusion in MIPPA contracts, they are prefaced by a reference to seeking input from stakeholders and the term “such as”, so we believe MMCO has discretion to consider alternative suggestions to those specifically mentioned in the statute. MMCO could designate some of these items as mandatory basic

requirements, while others could be optional alternatives available to plans and states by mutual agreement depending on the benefit design and other circumstances in each state. Following are some suggested items that could feasibly be included in MIPPA contracts across all plans regardless of benefits directly provided or integration continuum status.

- a. Ongoing communications process (based on current MMCO experience with states and plans in D-SNPs such as MN and MA) such as a monthly call between state, plan and CMS for significant changes, non-renewals, service area expansions, problem solving, FIDE SNP decisions, marketing and member materials coordination, education on policy changes, etc.
- b. D-SNPs could share their Model of Care (MOC) with the state. Where focused on single state, D-SNPs could add provisions related to how the D-SNP plan coordinates care with or provides state MLTSS and or BH benefits specific to the local geography and delivery system. In this scenario, states could work with D-SNPs to review the MOC and related MLTSS or BH provisions, and this could be handled outside of the current NCQA review process so as not to disrupt that process or timelines for MOC approval and implementation, as tested under the Minnesota D-SNP demonstration.
- c. A process for coordination of Medicare service delivery for members in unaligned Medicaid plans, fee for service Medicaid or to the extent feasible, receiving MLTSS and BH services that are carved out.
- d. Assure enrollee has chosen a PCP (or appropriate specialist or health care home) and facilitate a choice or access to PCP or appropriate health professional if enrollee does not have one.
- e. Assign members a primary plan contact person such as an NP, PCP, care navigator or care coordinator with responsibility to facilitate appropriate care access across both Medicare and Medicaid.
- f. Facilitate shared information about care coordination processes and primary plan contacts in e. such as care coordination or navigation contacts (available to network and non-network providers, including between unaligned plans) so that relevant parties know who to contact about care transitions, such as hospitalizations and hospital discharges, emergency room visits, nursing home admissions and discharges, and implementation of in-home services. (States may not have the capacity to receive, process and share this information with the appropriate parties at the state level, however both plans and states could work to improve systems for facilitating this information exchange at the provider and care coordinator level through enhancement of existing D-SNP transition protocols, shared care planning information and other provider to provider communication tools.)
- g. Shared monthly enrollment data between plans and states (including for unaligned enrollments); state to share data or develop some alternative method for data exchange and coordination between unaligned plans and or providers
- h. If state has systems capacity, request shared data on utilization such as Medicare encounters.
- i. Share key performance data with state (such as Star Ratings, G&A, CAHPs, HOS, audit results).
- j. Share/coordinate information on proposed supplemental benefits with states (consult with or provide to state at earlier date to facilitate better coordination with state MLTSS benefits)

The SNP Alliance recommends that CMS draft regulatory language that is sufficiently broad in order that CMS retains the flexibility through sub-regulatory guidance to revise requirements to address unanticipated issues as they may arise. The SNP Alliance looks forward to additional opportunities to provide feedback and input as the sub-regulatory and regulatory process moves forward.

### **3. Establishment of Incentives for Higher Levels of Integration**

For plans that meet increasingly higher levels of integration across the continuum, MMCO should consider additional rewards/ incentives, such as additional flexibilities and reduced administrative burdens based on proportions of enrollment alignment and assumption of clinical and financial responsibility as described below.

The MMCO could request states and plans to submit a joint plan for achieving a mutually agreed upon level of increased goals for integration, enrollment alignment and/or timelines for meeting FIDE SNP status or higher levels of integration where this is possible, along with a request for access to additional assistance and incentives needed to assist in reaching these goals.

MMCO could provide access to technical assistance for the plans and states as well as establish and publicize certain pathways and incentives designed and needed to assist in meeting additional levels of integration based on the plan submitted by the state (such as the options for FIDE SNP incentives below).

### **4. Option Two (FIDE SNPs or D-SNPs with Capitated Medicaid Contracts for MLTSS or BH)**

This option corresponds to paragraph (D)(i)(II) in the statute. Plans meeting this level of integration criteria would clearly include FIDE SNPs. FIDE SNPs by definition have highly aligned enrollments, allowing for aligned operational and administrative features. Some other non-FIDE SNPs also have achieved high levels of integration outside of FIDE status. However, this option in the statute also includes D-SNPs with capitated Medicaid contracts for MLTSS or BH, without specifying any definition or level of integration for those situations. We are aware that many of these non-FIDE situations include plans with significant proportions of members who may be enrolled in a different Medicaid plan or in FFS for LTSS or BH making it difficult to achieve a higher level of integration. In addition, there are some integrated plans that are interested in being more fully integrated, but face barriers due to state policies around inclusion of benefits or carve outs within their capitations.

We believe that it is reasonable that Congress, in enacting this provision, intended that these D-SNPs engage in additional coordination and/or integration activities for Medicaid services for which they are not directly responsible. Therefore, we recommend that non-FIDE SNPs under this option should meet the minimum criteria in Option 1. States and plans in this situation could also be encouraged to work toward higher levels of integration such as FIDE SNP or a newly defined highly integrated status where possible through various tools, flexibilities and incentives suggested below.

In order to encourage additional movement toward higher levels of integration, we also recommend that MMCO develop a set of incentives, reduced administrative burdens and

privileges, with consideration of those suggested below and others that could be developed through further collaboration with stakeholders, that could apply to FIDE SNPs and those D-SNPs that MMCO determines meet a similar level of integration and aligned enrollment to FIDE SNPs such as those providing integrated MLTSS and/or BH benefits with highly aligned enrollment. (For highly integrated DSNPs that are not FIDE SNPs, recognizing that some members must stay on the plan temporarily when they lose dual status, MMCO could set a threshold for a percentage of enrolled members that is considered full alignment depending on experience gleaned from enrollment experience from most FIDE SNPs).

Therefore, in order to strengthen the business case for plan and state interest in achieving this higher level of integration status and to increase the number of plans in more fully integrated arrangements, we recommend MMCO attach a combination of incentives and rewards to the FIDE and aligned/highly integrated D-SNPs such as those outlined below:

- a. MMCO should clarify expectations for states and plans for achieving FIDE SNP status, including providing transparency and clarification of the current review process and current criteria through guidance and/or additional educational materials. The current process is unclear to both states and plans, and criteria for requirements are not applied consistently. While we support some flexibility related to carve outs and populations in accordance with state policy, criteria for such flexibility should be clearly understood, and applied fairly across states and plans.
- b. MMCO should undertake a review of D-SNPs with highly aligned enrollments who are not currently FIDE SNPs to determine why they are not FIDE-SNPs and assist in removing barriers to FIDE SNP status.
- c. MMCO should also examine the schedule for determining FIDE SNP status and HOS frailty scores comparisons for access to the frailty adjuster to determine whether they could be adjusted to provide earlier notice. Some plans receive notice of these determinations too late in the contract year to fully utilize any additional benefits that might be facilitated through the adjustment or too late to work with states on implementation of additional integrated features.
- d. MLTSS Carve outs: MMCO should use the current FIDE SNP criteria for inclusion of MLTSS to avoid disruption of current FIDE SNPs. MMCO should address the current lack of consistency in reviews under current standards but should not increase the standard. However, MMCO may want to consider a more flexible stance on carve outs for states with significant barriers to capitation of MLTSS services in cases where the state is committed to pursuing higher levels of integration outside of capitations when coupled with strong coordination requirements enforced through additional MIPPA contract features.
- e. Behavioral Health (BH) Carve Outs. Since states and plans may have less experience with this new statutory provision, MMCO should take a flexible approach to the integration standard for carving in or carving out behavioral health including substance use disorder (SUD) including learning from current models with respect to effects on integration across behavioral and medical health services to the beneficiary, considering allowing partial carve outs, and focusing on creating new opportunities to improve coordination of physical and mental health benefits. MMCO could look at the magnitude of Medicaid-covered behavioral health and substance abuse services and relevance to effective care management functions included in the plan's capitation and recognize that in many states significant BH and SA services may be provided outside of Medicaid or

through grant-based funding that may not easily be included in capitations. MMCO could also consider the state's ability to capitate such Medicaid services under state laws and consider alternative coordination arrangements for carved out benefits.

- f. Strengthen administrative incentives and rewards for movement toward FIDE SNP status for both plans and states through:
  - i. Expansion of the new passive enrollment and seamless default enrollment Medicare rule provisions for FIDE SNPs by creating an option for ongoing periodic passive enrollment/auto-assignment of dual beneficiaries in Medicaid plans into a matching Medicare plan under the same sponsor (with opt out provisions) for approved FIDE SNPs (similar to MMP process.)
  - ii. Facilitated policies for application of deeming of Medicaid eligibility for 2-3 months and rapid re-enrollment strategies used by MMPs to D-SNPs.
  - iii. A flexible SEP which allows enrollment of dually eligible beneficiaries into the integrated plan all year (similar to enrollment policies for 5 Star plans).
  - iv. Alignment of enrollment effective dates to reduce consumer and provider confusion and facilitate integration upon initial enrollment. This task will be complicated by the new SEP limitations for duals which, though improved from the initial proposal, may still preclude some dual beneficiaries who may have used up all applicable SEPs, from choosing an aligned integrated D-SNP at the same time as they may be required to enroll in a Medicaid managed care or MLTSS plan.

Having separate Medicare and Medicaid enrollment effective dates for members who are attempting to enroll in an integrated program causes tremendous confusion at the front end for beneficiaries and providers, as well as additional administrative burdens for plans around service responsibility, benefit determinations, claims processing and billing, because it is not clear which service is billed to each payer or whether and when to bill the new plan vs a previous arrangement. In general, D-SNPs are not allowed to "hold" enrollment forms to ensure that enrollments match the correct Medicaid plan and effective dates.

To avoid this problem MMCO/CMS could consider allowing the Medicare D-SNP to hold the enrollment form for a short period (30-60 days) for the purpose of allowing enrollment effective dates to align with the matching Medicaid plan in these cases.

- g. Offer additional administrative features from MMPs and MN DSNP demo to all FIDE SNPs such as including MLTSS and/or BH integration in MOCs (outside of NCQA review, use of MMP network review and exceptions process, integrated member materials, MN premium protection feature: where margins have a minimum of zero, allows broader margin comparisons to commercial products under bid rules to avoid premiums for dual beneficiaries.
- h. MMCO should provide added benefit flexibility above and beyond those newly announced in the Medicare rule and Call Letter to apply to all MA plans for FIDE SNPs as an incentive for plans and states. (This could be included in revisions of current FIDE and Highly Integrated D-SNP guidance in the MM Chapter 16b.)

- i. Continue to revise IDN model notice and instructions to streamline alignment and reduce unnecessary notices to beneficiaries.
- j. Work with states and plans to develop a list of options for reduced administrative burden that would be applicable only to FIDE SNPs/and or plans with higher quality and higher levels of integration.
- k. Improve PACE frailty score comparison through HOS/HOS-M and Frailty Adjustment revisions:
  - i. For frailty adjustment, compare and apply frailty scores only from the proportion of dually eligible enrollees with MLTSS who are at institutional level of care within the FIDE SNP enrollment for an apples-to-apples comparison of the FIDE SNP population frailty status to the PACE population.)
  - ii. Conduct HOS/HOS-M reporting at the D-SNP PBP level
  - iii. Rescale health status questions
  - iv. Provide HOS/HOS-M in additional languages
  - v. Allow interpreter assistance for HOS/HOS-M
- l. Separate H numbers or PBP level reporting: MMCO should consider allowing FIDE SNPs and D-SNPs with highly aligned enrollments as defined here (when included in larger contracts among multiple PBPs) to voluntarily apply for separate H numbers for PBP level reporting to enable streamlined and improved accuracy in reporting reflecting the enrollees of integrated/aligned plans with cut points specific to SNP types. CMS should eliminate some duplicative reports and/or consolidate reports to streamline the process, such as using one CAHPs for both programs. Reporting G&A at the PBP level could also pathways for integrated G&A reporting for Part C and Medicaid services, and avoid confusion in Part D reporting which could remain separated.

## 5. Option Three

This option corresponds to (D)(i)(III) which pertains to D-SNPs offered by a parent organization that is also the parent organization of a Medicaid managed care organization providing LTSS or BH assuming clinical and financial responsibility for both benefit sets. Similar to the situation under Option Two, enrollment in such plans may not be aligned, with some proportion of members also enrolled in some other sponsoring organization’s Medicaid plan.

MMCO asks whether they should consider a parent organization to have such “clinical and financial responsibility” where the state requires aligned enrollment (i.e., enrollment in the D-SNP is limited to enrollees in the same parent organization’s Medicaid managed care product.) MMCO also asks whether there are any circumstances other than aligned D-SNP and Medicaid managed care enrollment under which an organization could demonstrate “clinical and financial responsibility” for benefits.

We believe that any D-SNP with a capitated managed care contract for provision of services under Medicaid for LTSS and/or BH or both (including non-FIDE SNPs included under Option Two) is assuming clinical and financial responsibility through both of their contracts for any services they are providing to enrollees under each of those contracts regardless of alignment of enrollment. Therefore, it would be hard to argue that such clinical and financial responsibility is limited to members enrolled only in fully aligned plans.



We point out that accepting clinical and financial responsibility for both benefit sets is not the same as being integrated, since integration is highly dependent on the alignment of enrollments between the Medicaid and Medicare plan under the parent organization. Therefore, as under Option Two, we suggest plans under Option Three should at least meet the minimum criteria outlined in Option One and should be encouraged to work with states to align enrollments and become FIDE SNPs or highly integrated D-SNPs to access the additional incentives provided to that category of plans, to the extent feasible under a state's program design and as appropriate to the population.

We also suggest it may be necessary for MMCO to clarify whether there are or should be any distinctions made between D-SNPs offered by a parent organization that is also the parent organization of a Medicaid managed care organization providing LTSS or BH or both under Option Three, and non-FIDE SNPs with capitated managed care contracts for LTSS or BH or both meeting requirements under Option Two.

An important overarching question related to integration for both of these situations is whether the plan or the parent organization has administrative processes in place to assure that service delivery is coordinated or integrated across both contracts and to simplify navigation for enrollees across both programs. So, in order to meet the clinical and financial responsibility conditions in the statute, it is reasonable to apply the minimum integration standards to plans in this category, in addition to additional activities that MMCO could encourage increased integration for both groups of these plans as stated below.

In these cases, the plan or parent organization could agree to:

- Employ an integrated management approach to assure integrated Clinical and Financial Responsibility across both products.
- The D-SNP MOC should provide one principal care coordinator across both products for all enrolled members regardless of aligned enrollment.
- Integrate member service contacts (e.g. one number with designated or specially educated staff) for all dually eligible members to call for both Medicare and Medicaid questions and assistance.

## **6. Increased Messaging and Tools For States**

The MMCO should develop and facilitate stronger tools, supports, incentives and encouragements for states to achieve enrollment alignment reflecting a stronger stance on the benefits of integration and advantages of enrollment alignment to whatever degree is possible given the state's capacity through the following activities:

- a. Continue to increase efforts to offer support, technical assistance and guidance around integration concepts and features, including continued and additional outreach to non-integrated or low integration states.
- b. Develop stronger education/messaging to states re: conflicting incentives involved with dual beneficiaries enrolled in two separate plans, based on current evaluations and other research.
- c. Provide additional templates and models for strengthening MIPPA contract features and language, as well as member materials and notices for use by plans and states and streamlined contracting and renewal processes.
- d. Provide additional tools for increased alignment by encouraging states to employ methods for auto-assignment of existing Medicaid members to FIDE SNPs and work

- with CMS Medicaid to ensure that any related Medicaid requirements involved are streamlined.
- e. Support and encourage state implementation of expanded passive enrollment options as outlined earlier as well as the new default enrollment option.
  - f. Look for additional areas of state-specific administrative streamlining and facilitate solutions or provide rewards by reducing duplicative processes or facilitating additional data sharing between states and plans and providers.
  - g. Compile research, conduct surveys on specific integration features to learn more about the barriers states and plans face to see where small changes might produce additional movement towards integration.
  - h. MMCO could develop self-evaluation tools for states to determine integration levels and barriers. MMCO could also rank states on an integration scale using objective integrated features.
  - i. MMCO could make an annual request to states to assess interest in submitting a plan for pathways to FIDE SNP or increased integration status for approved D-SNPs with which they have MIPPA contracts. MMCO should document where states decline interest and reasons for such and include this information in their annual RTC.
  - j. In order to work toward implementation of the unified G&A process, MMCO could establish a stakeholder work group to make recommendations for development of common language and materials and tools for states and plans to utilize in education of all stakeholders about changes in the process.
  - k. In order to facilitate improved coordination of benefits in D-SNPs with unaligned members, MMCO could develop or work with states to develop standardized data sharing mechanisms that would facilitate ongoing data exchanges for identification of D-SNP enrollees enrolled in an unaligned Medicaid plan or in FFS. These data exchanges should also provide for consistent nomenclature and descriptions for different dual eligibility categories to be used by states and plans across the country.
  - l. Annual request to states to assess interest in submitting plan for pathways to FIDE SNP status for approved D-SNPs with which they have MIPPA contracts. MMCO should document where states decline interest and reasons for such and include this information in annual RTC.

## **SECTION II: UNIFIED GRIEVANCE AND APPEALS (G&A) SYSTEM**

### **A. Approach**

Due to the myriad of differences remaining between state and Medicare processes and timelines, it will be necessary to interpret the new statutory G&A provisions in a way that permits these CMS requirements to take precedence over conflicting state requirements in order to achieve a unified G&A system for implementation by 2021. The statutory language at (8)(B)(i) “With respect to items and services described in the preceding sentence, procedures established under this clause shall apply in place of otherwise applicable grievance and appeals procedures.” seems to support this interpretation.

Unfortunately, the SNP Alliance does not have enough access to the level of detail of information about differences in state Medicaid process and timelines required in order to develop practical and constructive answers to some of the questions included in the RFSI. We suggest that MMCO convene a group of plan and state subject matter experts along with other stakeholder representatives

such as the SNP Alliance and Community Catalyst, to address some of those questions more fully. In the meantime, we are pleased to have this opportunity to provide the following recommendations for a broad framework for approach to development the Unified Grievance and Appeals System.

1. MMCO could develop minimum standards for a unified G&A process, by building on the MN DSNP demo G&A process as a broad model for a standard aligned approach. Other FIDE SNPs report applying a similar approach. This approach utilizes integrated timelines for the plan level grievance and appeals, with an integrated benefit determination and notice to the member, which reduces the number of issues that must go beyond the first level. If the determination is unfavorable to the member, the matter is forwarded to the appropriate entity for second level review, depending on which payer is responsible for the original service requested. Initially, this approach might be preferable to establishing an entirely new infrastructure for second level appeals (such as that used in New York) which could be more expensive and confusing as well as more disruptive to normal state processes. However, a single entity could be considered long range, as more plans become aligned and integrated. In the meantime, since we believe application of the unified systems is highly dependent on the level of enrollment alignment in a plan (see item 4. below), it provides a reasonable incremental middle ground, until there are more fully integrated plans capable of utilizing any new infrastructure.
2. Because integration levels vary dramatically across states, we suggest that MMCO apply the full unified system initially only to FIDE SNPs and/or plans with highly aligned enrollment such as discussed earlier under Option Two. As more plans become more integrated and achieve increased aligned enrollment through pathways described above and as there is more experience with the unified G&A system, MMCO can consider additional refinements and broader application of the unified G&A provisions to additional plans.
3. As a prerequisite to being able to extend use of the uniform G&A system to other plans beyond those serving the same enrollees in both Medicare and Medicaid, MMCO will need to assure that processes are in place for accurate and timely ongoing data sharing between D-SNPs and unaligned Medicaid plans. This data needs to specify both the D-SNP and Medicaid plans in which the member is enrolled, and the eligibility level for Medicaid coverage in order to coordinate between both entities involved in care.
4. However, in the meantime, as MMCO learns more about how the unified system could work, there may be certain elements of the unified system that could be applied to D-SNPs regardless of integration status. MMCO might identify those and adopt some incremental improvements that could apply to all D-SNPs short of the full system where more feasible such as the timeline discrepancy examples in items 5. and 6. below.
5. While both Medicare and Medicaid now have the same standard of 30 calendar days for resolving appeals as well as the option to extend the timeframe by an additional 14 days upon member request or for “good reason”, not all states have opted to adopt this extension in their MIPPA contracts. As an incremental step to achieving the uniform G&A process, MMCO could require or encourage that all states include this extension in any MIPPA contracts with D-SNPs.
6. Although both Medicare and Medicaid require that appeals be resolved within 30 days, Medicaid does not make a distinction between pre- and post- service appeals, whereas Medicare requires allows 60 days for resolution of post service appeals. In order to align and simplify this issue in the new unified system, we recommend that MMCO consider adopting the 60-day standard for post service appeals where the enrollee has already received the service and care will not be disrupted.
7. When considering other timelines and process differences between Medicare and Medicaid, utilize the most protective timeline and or process for beneficiary, in making further decisions on

how to achieve further alignment of conflicts between Medicare and Medicaid. For example, some states allow grievances for broader issues not directly involving negative benefit determinations, and MMCO should consider how those can be retained in the new unified system.

8. Attempt to attain an overall consistency in the standard model to simplify messaging to beneficiaries but allow some state-level flexibility since it may be necessary to identify areas where a process or timeline may need to vary within the standard approach due to state-level requirements embedded in Medicaid. Where a process already works well, the system should accommodate some state flexibilities.
9. Maintain separate state and CMS reporting requirements but reduce administrative burden by increasing alignment of reporting timelines and formats for basic elements reported. Avoid reporting changes that impact current Part D reporting due to the complexities involved with Part D. We assume that Part D appeals and reporting would remain separate, however, D-SNPs might be encouraged to share Part D appeals summaries with states.
10. Reporting could also be clarified by collecting information at the PBP level for FIDE-SNPs or allowing FIDE-SNPs to volunteer for separate contract numbers as discussed earlier.
11. The MMCO should review difference in definitions and terminology related to G&A between Medicare and Medicaid and work with Medicaid colleagues for further alignment to simplify model language appropriate to both.
12. Seek alignment of additional related notices and model materials on G&A, shorten the length of the notices and simplify the messages and language used. D-SNPs under an umbrella contract may need to be allowed to use separate materials from MA plan or non-dual members.
13. We are hopeful that the legislative provision in 1852(g)(1)(b) will simply notices for situations where integrated D-SNPs were required to send notices of denial for items not covered by Medicare, even though they do intend to cover them under Medicaid. This was very confusing for members, since the plan has been promoted as an integrated program and the plan/sponsor will in most cases, be covering the service under one program or the other. In these cases one notice stating that the service will be covered under Medicaid should be sufficient. Of course, if the plan is not covering the service under either benefit, a notice along with appropriate appeal rights must be sent. Such notices then should state whether the benefit is or is not a covered service under either benefit and/or under which program (Medicaid or Medicare) the benefit is being denied.
14. Align Medicare and Medicaid notices for letters related to delegated arrangements where the benefit is plan covered, but the delegated entity is responsible for determinations and the plan is sending the member a notice that they should contact that entity. Currently Medicare does not require that an appeal notice be sent with such letters since the determination is not yet made, but some states do require Medicaid appeal rights notices in these instances, which makes those notices and subsequent notices even more confusing to beneficiaries.
15. Non-contracted medical provider appeals and waivers of liability for past service disputes: Under Medicare, non-contracted providers pursuing a G&A submit a waiver of liability which assures they are acting on their own behalf and will not charge the beneficiary, thus no member written consent sign off is needed. However, under Medicaid members may have to sign for the provider to submit an appeal. MMCO should follow the Medicare process because it is less complex and remains protective for the beneficiary.
16. Under the new system MMCO should provide for consistency between G&A processes for network and non-network providers. Non-network providers may file appeals for non-covered or non-medically necessary services for which they then bill the enrollee even though they are not supposed to. FFS Medicare providers are not allowed to do this and must provide a special

advance notice of non-coverage to beneficiaries when Medicare coverage is expected to be denied. The new unified system should require that non-network providers or allow D-SNPs to require them to use a similar notice under MA and should provide additional guidance to these providers to coordinate information with D-SNPs in these instances.

### **SECTION III. OTHER RECOMMENDATIONS TO IMPROVE ALIGNMENT AND INTEGRATION**

#### **A. Facilitate Record and Information Sharing**

In order to enable optimal care coordination, MMCO can encourage CMS to do more to facilitate information sharing and streamline and simplify authorizations to release information, including behavioral health and substance abuse information, between various providers, providers and health plans and during health plan transitions. We recognize that this is a very large and broad issue, complicated by federal and state data confidentiality provisions. However, SAMHSA and the National Association of State Mental Health Program Directors have been working on HIT and information sharing strategies to overcome these barriers, and now that BH is included in statutory options for integration, we are hopeful that further collaboration at the federal level could facilitate sharing of best practice models and protocols that allow such information to be shared more easily at the provider to provider and plan to plan level to facilitate improved care coordination across physical and behavioral health service delivery systems.

#### **B. Value of D-SNP Platform to All Dual Beneficiaries including Partial Duals**

The SNP Alliance believes that enrollment in D-SNPs provides significant benefits to duals and partial duals that are not available in regular MA plans. Dually eligible beneficiaries, including those with partial dual status, experience higher levels of barriers to health care due to low incomes and various Social Determinants of Health (SDOH) factors and many become Full Benefit Dual Eligibles (FBDEs) due to changes in health status such as need for LTSS and BH services. Unlike general MA plans, D-SNPs are required to have Models of Care including enhanced care coordination strategies designed to address the special primary, acute and chronic care needs of dually eligible beneficiaries which apply to and benefit those with partial eligibility as well as FBDEs.

Enrollment of partial duals in D-SNPs provides access to more intensive clinical models of care and care management of acute and chronic conditions to a population that may either remain in FFS or be overlooked as part of general MA plans. D-SNP Models of Care include access to individual Health Risk Assessments, Individualized Care Plans with goals for care, Interdisciplinary Care Teams and Transitions of Care Protocols, as well as provision of additional training to providers about the special needs of enrollees and other features. These features are not required in general MA plans. Like other dually eligible beneficiaries, partial duals are best served through coordinated care models that address complex needs that are both social and clinical in nature which are required under MOCs, but not required for general MA plans. Eliminating eligibility for SNP enrollment would force the beneficiary into a plan type that is not designed for care integration or coordination, limiting opportunities for the preventive and proactive care planning typical of a coordinated care model and leading to a burden on the beneficiary and a potentially higher cost burden on the health care system.

Further, states are increasingly interested in strategies for serving partial duals and other LIS populations that are often referred to as “pre-duals”, because poor management of chronic conditions

leads to higher levels of frailty and LTSS needs for which partial duals are not initially eligible. After struggling to afford access to LTSS services to remain at home or pay for nursing home care, many beneficiaries in this situation exhaust their already low income and assets and “spend in” to FBDE status where states share more financial responsibility for care. In these cases D-SNPs can assist in accommodating individuals where they are in their medical complexity, working to prevent escalation into the next level of care, or providing continuity of care when individuals must move into full dual status.

AARP research reports (see link below) indicate that most states pay for some LTSS benefits for low income seniors not eligible for full Medicaid benefits out of state funds, having determined through experience that access to even a small package of in home services can reduce depletion of resources into FBDE status and is less expensive to them. D-SNPs are the strongest available and ready platform for working with states on additional care coordination and community services links to such state funded services and mechanisms that can help improve care for partially eligible dual beneficiaries. Forty-one states are already invested in relationships with D-SNPs and are familiar with basic MIPPA contracting. With the potential of additional flexibility in supplemental benefits, there are also new opportunities for states to collaborate with D-SNPs to design benefits of particular value to partially dual beneficiaries in addressing their chronic care needs, complementing strategies some states are already pursuing for the partial and “pre-dual” populations. D-SNPs can also tailor supplemental benefits and how they use their rebates in ways that general MA plans serving the broader Medicare population would not normally choose. For example, since partial duals receive the Part D low-income subsidy and cost-sharing coverage, D-SNPs may be less focused on using rebates to buy down premiums or cost-sharing than are general MA plans and instead may use the rebate to offer a more tailored package with extra benefits that make sense for this population. These tailored benefits likely would not be offered by a standard MA plan serving the broader Medicare population, which positions D-SNPs to better complement and coordinate with existing state programs.

*State Funded HCBS by Robert L. Mollica, National Academy for State Health Policy, Kristin Simms-Kastelein, National Academy for State Health Policy, Enid Kassner, AARP Public Policy Institute, April 2009* [https://www.aarp.org/health/medicare-insurance/info-04-2009/2009\\_06\\_hcbs.html](https://www.aarp.org/health/medicare-insurance/info-04-2009/2009_06_hcbs.html)

The numbers of partial duals are expected to continue to increase, but the proportions of partial dual beneficiaries vary tremendously by state, depending on state financial eligibility criteria. Based on MedPAC data, though on average partial duals make up about 28% of the total dually eligible population, this ranges from a low of 3% in CA to a high of 57% in AL, with a skewed distribution where many southern states tend to be grouped either at the higher ranges of 40-55% or a lower range of 10-20% in northern or eastern states. In some of these states, large numbers of partial duals have come to rely on D-SNPs for Medicare coverage tailored more specifically to their needs and elimination of this option would reduce their access to beneficial care models and services. Therefore, we believe D-SNPs are an important resource to low income disadvantaged seniors and people with disabilities who are partial duals and should be considered a part of the integration continuum.

However, we recognize that complications arise for application of integration standards to D-SNPs serving largely partial duals or both partial duals and FBDEs. Member materials and notices become much more complex, performance information and data reporting is compromised and it is clear that many of the proposed integration standards around integration of benefit delivery could not easily apply to the partial dual population, though stronger mechanisms for coordination with community

resources could still be required for this group. Because of this, we recommend that D-SNPs with large numbers of partial duals establish separate PBPs for serving this group and that reporting at the PBP level for such D-SNPs be considered as part of the study on PBP level reporting required under the new statute.

### **C. Integration for C-SNPs and I-SNPs Serving Dual Beneficiaries**

When considering integration standards for dually eligible beneficiaries, MMCO should also look at opportunities to extend additional flexibilities and alignment mechanisms that would facilitate or promote further integration of Medicare and Medicaid service delivery for dually eligible beneficiaries served in C-SNPs such as those focusing on HIV-AIDs and Behavioral Health, and I-SNPs whose enrollees also may also be predominately dually eligible beneficiaries. We believe MMCO now has additional authority and responsibility to address alignment for dually eligible beneficiaries enrolled in these SNPs, under the recent amendment to 42 U.S.C. 1315b (d) which states that the MMCO is “responsible, subject to the final approval of the Secretary, for developing regulations and guidance related to the integration or alignment of policy and oversight” under Medicare and Medicaid regarding “specialized MA plans for special needs individuals”.

### **D. Strengthening Models of Care**

MMCO should identify and disseminate best practices among D-SNPs that have strengthened current MOC care transition protocols and methods to improve continuity of care across both Medicaid and Medicare services among providers who serve the same person, either at the same time, e.g. such as for frail elders, or in sequence to one another, such as related to hip fractures and strokes. (Care transition relates to movement between providers; care continuity relates to providing complementary service arrangements.)

MMCO should support D-SNPs to move toward specialty care arrangements for defined population segments, such as for frail elders and adults with disabilities through redesign of network standards and value-based purchasing arrangements that can best achieve this move to population health. For example, supply may not be the best way to drive quality of care. Delivery systems should enable and support sharing of person-centered care plans including goals and interests and information based on beneficiary and/or caregiver involvement with key providers involved in a person’s care.

MMCO should work with other areas within CMS to better align measures across settings of care so that persons with complex needs spanning medical, behavioral, and social health/support services have a core set of quality measures which will help identify key quality gaps and drive coordinated quality improvement efforts. MMCO should consider opportunities to extend the development of the QMS/QRS for MMPs to consideration of quality standards and measures for FIDE SNPs and integrate, streamline, and refine measures, as well as reduce reporting of duplicative or conflicting measures.

### **E. MMPs and D-SNP Demos as Learning Laboratories**

MMCO should further utilize the existing MMP and MN D-SNP demonstration programs as continued opportunities and learning laboratories for testing and developing additional integration features and processes that could be exported to FIDE SNPs and other highly integrated D-SNPs including other types of shared savings models for states. In addition, recognizing that testing of some administrative features may not warrant an entire formal evaluation, MMCO could work within CMMI authorities to identify additional demonstration and waiver opportunities that build on what we have learned thus far. If there are limitations under current demonstration authorities,

MMCO could propose additional or revised authorities, and/or continue to work with states, congress, CMS, CMMI and private foundations to identify and fund needed resources and evaluation mechanisms for states and D-SNPs or MMPs that wish to pursue additional integration initiatives.

For questions and follow up discussion about these recommendations, please contact Pamela Parker, SNP Alliance Integration Consultant, at 612-719-5845. [Pparker2@comcast.net](mailto:Pparker2@comcast.net).

Thank you for the opportunity to provide comment on these important areas of integration affecting dually eligible beneficiaries.

Sincerely,

A handwritten signature in cursive script that reads "Cheryl Phillips, MD".

Cheryl Phillips, M.D.  
Special Needs Plan Alliance