National
MLTSS
Health Plan Association

April 12, 2018

Director Tim Engelhardt
The Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office")
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

Response to Request for Stakeholder Input: Implementing the D-SNP Provisions of the Bipartisan Budget Act of 2018

Dear Director Engelhardt:

Thank you for the opportunity to provide comment on the Medicare-Medicaid Coordination Office (MMCO)'s request for stakeholder input on implementing the dual eligible special needs plans (D-SNP) provisions of the *Bipartisan Budget Act of 2018*.

The National MLTSS Health Plan Association is an association of health plans that contract with states to provide managed long-term services and supports (MLTSS). Our members currently cover about 75 percent of enrollees in MLTSS plans and assist States in delivering high quality services at the same or lower cost as the fee for service system with a particular focus on ensuring beneficiaries' quality of life and ability to live in the community instead of an institution. Responsibility for managing an LTSS benefit also extends to our members' offerings through D-SNPs and Medicare-Medicaid Plans (MMPs). Member organizations include Aetna Inc., AmeriHealth Caritas, Anthem Inc., CareSource, Centene Corp., Commonwealth Care Alliance, Health Plan of San Mateo, L.A. Care Health Plan, Molina Health Care Inc., Tufts Health Plan, UPMC Health Plan, and WellCare Health Plans Inc.

The Association supports efforts to move toward a more integrated and seamless system of care for all individuals with LTSS needs, especially those who have dual eligibility for Medicare and Medicaid. As CMS implements the requirements enacted in the *Balanced Budget Act (BBA) of 2018* in pursuit of this goal, we recommend that you take into account the variation that exists between states and plans in what is considered "integration" and how this is consistent with the intent of the Act. We encourage CMS to articulate through rulemaking specific dimensions that characterize integration and allow for plans that have been operating different approaches in different state environments to gradually and effectively make the transition to greater integration while minimizing the impact of this transition on dual-eligible beneficiaries. The Association supports an approach to this transition that ensures that D-SNPs have the opportunity and the time to transition to a more fully integrated approach without disrupting the marketplace.

As acknowledged by the request for stakeholder input, the *Bipartisan Budget Act (BBA) of 2018* was passed into law on February 9, 2018. Within the bill, Section 50311(a) permanently authorized all forms of SNPs while Section 50311(b) required the Secretary of the Department of Health and Human Services to develop an aligned grievances and appeals process for D-SNPs ("to the extent feasible") by April 1, 2020 and required that all D-SNPs meet one or more of a set of integration requirements put forth in the legislation by 2021 and subsequent years. To a certain extent, these requirements for integration follow a gradual trend within Congress (e.g. D-SNP contracting requirements through the Medicare Improvements for Patients and Providers Act), current and past Administrations (e.g. seamless conversion), States (e.g. pursuit and implementation of Financial Alignment Initiative Demonstrations), and the broader stakeholder community (e.g. investments from health plans in developing and testing integrated care delivery models) towards a more integrated delivery system.

Requirements for Integration

The Association strongly supports the goals and spirit of the requirements in the Act for greater integration and recommends that plans be afforded a proper and sufficient transition period in recognition of the number of programmatic, policy, and IT changes plans will need to implement to become compliant.

Our recommendations below only address circumstances where any D-SNP exists in a state that operates an MLTSS program by contracting with one or more Medicaid managed care organizations, regardless of any service carve-outs. However, we recognize that language of the Act covers a broader set of circumstances.

> *Subsection (D)(i)(I) lists examples of potential requirements for integration. We welcome comments related to those examples.*

The Act puts forth three potential requirements for D-SNPs coordinating with a State Medicaid Agency that the Secretary could establish under Subsection (D)(i)(I): notifying the state in a timely manner of hospitalizations, emergency room visits, etc.; assigning one primary care provider for each enrollee; and sharing data that would benefit the coordination of items and services. The Association believes these activities are potential steps in the path toward a more integrated and coordinated system, but CMS should develop a more detailed and nuanced set of requirements for states and plans to pursue and take a more active role in ensuring dual-eligible individuals receive coordination of their medical and non-medical care.

> *Other than those explicitly mentioned in subsection (D)(i)(I), additional D-SNP activities CMS should consider requiring as integration standards in the state Medicaid agency contracts to meet the requirements of subsection (D)(i)(I)*

The following is a set of practices that plans and states can implement, in part or in whole, to "actively" pursue a more integrated delivery system, with the recognition that CMS should provide the technical assistance and resources necessary for certain states and plans that are in the early stages of developing this level of integration:

- Craft a Medicare benefit package that is aligned with the member's aligned MLTSS/behavioral health benefit package, as currently practiced in Medicare-Medicaid Plans (MMPs);

- Integrate administrative, IT, communications, and financial systems that allow for real-time data exchange and coordination with the member's (un)aligned Medicaid MLTSS/behavioral health MCO to facilitate a seamless experience for the beneficiary and their providers;
    - This includes practices such as processes and member notices related to enrollment/disenrollment and grievances/appeals;
    - coordination and real-time exchange of assessment and care planning data; and
    - integrated authorization/coverage determinations and notices.
- Provide evidence that the D-SNP delegated all long-term care assessment, care management, and transition activities to the member's (un)aligned MLTSS MCO so the member has only one care manager and only one person-centered assessment, care management, and transition plan, which can be readily accessed by the beneficiary or providers, as necessary;
- Provide evidence that the D-SNP actively coordinates with the beneficiary's (un)aligned MLTSS/behavioral services MCO to facilitate the transition of individuals who can and want to live in a home- and community-based setting as opposed to an institutional setting.

How CMS should consider partial carve-outs of Medicaid services in applying the criteria in subsection (D)(i)(II) and (III)

The Request for Stakeholder Input acknowledges that CMS has an existing standard for considering partial carve-outs of Medicaid services to determine FIDE-SNP status.[1] The Association believes this is a reasonable standard to apply for the assessment of whether a FIDE-SNP meets one of the standards for integration.

The Association would also like to highlight that certain states have geographic carve-outs for their MLTSS programs and certain states who have newly implemented an MLTSS program utilize geographic phase-ins. As of January 2018, twenty-three states operate an MLTSS program, with approximately four others in the process of studying how to implement an MLTSS program.[2,3] As more states transition towards and implement their MLTSS programs, one strategy is to begin the implementation process in certain geographic regions eventually followed by state-wide implementation (e.g. Virginia and Pennsylvania). In the process of determining whether a D-SNP meets the integration requirements of a FIDE-SNP, CMS should recognize that states with newly functional MLTSS programs may have chosen to carve-out certain service areas, thus preventing plans from achieving full integration in certain regions.

Should CMS consider a parent organization to have "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)?

The Association believes that, where possible, dual-eligible beneficiaries with LTSS and/or behavioral health needs should be enrolled in aligned plans in which the Medicaid plan is responsible for coordinating

[1] MMCM Chapter 16b: "The plan must be at risk for substantially all of the services under the capitated rate; The plan must be at risk for nursing facility services for at least six months of the year; Individuals must not be disenrolled from the plan as a result of exhausting the services covered under the capitated rate; and the plan must remain responsible for managing all benefits, including any carved-out service benefits, notwithstanding the method of payment (e.g., fee-for-service, separate capitated rate) received by the plan."

[2] https://www.gao.gov/products/GAO-17-632

[3] This number is inclusive of states that have MLTSS programs not only through Medicaid MCOs, but those who have programs solely through the Financial Alignment Initiative (FAI) demonstration.

and managing LTSS and/or behavioral health services. In this instance, the parent organization should be considered to have "clinical and financial responsibility." However, this should not preclude beneficiaries without LTSS and/or behavioral health needs from accessing D-SNPs that have a Medicaid MCO contract that does not include managed LTSS or behavioral health services. As D-SNPs are required to meet one or more of the requirements for integration set forth by the BBA, these D-SNPs with Medicaid MCO contracts that do not include managed LTSS or behavioral health still have the opportunity to be certified as "integrated" for the population without LTSS or behavioral health needs.

The Association would also like to request that CMS issue sub-regulatory guidance on the definition of "parent organization," given that some D-SNPs have multiple legal entities.

Other Considerations

We would like to take this opportunity to voice our strong support for the Medicare-Medicaid Plans (MMPs) launched under the Financial Alignment Initiative (FAI). As Congress and CMS pursue a greater level of integration for dual-eligible beneficiaries, we believe it is key to maintain the programs' operations due to their success and the lessons they have and will provide. As certain state MMP programs near the end of their contracts, we urge CMS to make these programs permanent and to allow new states to establish their own MMP programs. In addition, we urge CMS to begin considering how it can encourage wider adoption of MMPs, based on the lessons learned to date by the demonstration, while preserving beneficiary choice through the continued offering of D-SNPs and other options.

Unified Grievances and Appeals Processes for D-SNPs

The Association agrees with the intent of the legislation to establish a unified grievance and appeals process for D-SNPs, to the extent that is possible. The variation among state Medicaid programs in defining benefits, services, cost sharing, etc. creates a number of difficulties in establishing a single process that all states and plans must follow. Therefore, we recommend that CMS adopt a common grievances and appeals framework to set a minimum standard for a unified system amongst states, but allow states the latitude to tailor certain requirements to account for existing programmatic variation that cannot be reconciled at the federal level.

Regardless of CMS's approach to creating a unified system, the Association believes beneficiary protection should be maximized and considered a top priority. In addition, we would like to emphasize that CMS should establish a common vocabulary among the programs with aligned definitions. To the extent that this is not possible, we ask that CMS create and share resources and technical guidance that helps delineate key differences between Medicare and Medicaid, especially as it pertains to timeframes, overlapping services, and terms that are present in one program but not the other.

How to ensure that the unified grievances and appeals processes for D-SNPs limit administrative burden on plans and providers, and improve beneficiary experiences

The Association recommends establishing clear, consistent, and aligned timeframes for grievances and appeals, including clarifying the use of calendar days as opposed to business days. Notably, the 2016 Medicaid Managed Care Final Rule (81 FR 27497) aligned the timelines for Medicaid appeals to be consistent with Medicare and the commercial marketplace. CMS should maintain this consistency between Medicare and Medicaid.

Other Considerations

As a separate consideration, the Association urges CMS to study and consider how creating a unified grievances and appeals process may impact a plan's performance under the Medicare Star Ratings System. As CMS implements this new unified system and as plans are required to move towards a more integrated care delivery model, the Association is concerned that the submission rate of grievances and appeals may disproportionately increase for D-SNPs relative to other Medicare Advantage (MA) plans. Due to this asymmetric burden on D-SNPs, the Association asks that CMS implement some form of adjustment or grace period for contracts with D-SNPs during this period of transition. In addition, following any transition period, CMS should ensure that contracts with D-SNPs are not disproportionately penalized relative to contracts that contain a majority of MA plans that solely serve Medicare-only beneficiaries.

Conclusion

The Association believes this is a critical opportunity for stakeholders across the health care community to move towards a more coordinated and integrated delivery system. Coordination of care across medical and non-medical sectors is critical to success in managing the quality of care, creating a seamless care experience for the individual and family, and managing state and the federal government expenditures. Integration of medical and LTSS coverage ensures individuals have the services and supports they need to remain independent in their homes and communities, and avoid unnecessary and expensive ER visits, hospital admissions and re-admissions, and institutionalization. As such, we look forward to future guidance and communication from CMS on these matters.

We welcome the opportunity to meet with MMCO staff to discuss our comments or the efforts of the Association. If you have any questions, please contact me at latkins@mltss.org.

Sincerely,

G. Lawrence Atkins
Executive Director