

# JUSTICE IN AGING

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April 12, 2018

By electronic delivery to [MMCOCapsmodel@cms.hhs.gov](mailto:MMCOCapsmodel@cms.hhs.gov)

Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services,  
Baltimore, MD 21244-8013

## Re: Comments on Section 50311

Justice in Aging appreciates the opportunity to respond to the Request for Stakeholder Input (“Request”) concerning implementing the Dual Eligible Special Needs Plans (D-SNPs) provisions of the Bipartisan Budget Act of 2018.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Justice in Aging appreciates that the Medicare-Medicaid Coordination Office (MMCO) solicited stakeholder input at the very start of the process to inform next steps related to unified D-SNP grievance and appeals processes and new integration standards. Having the chance to weigh in early is most helpful. Because the statutory requirements are so new, our comments are necessarily preliminary and we welcome additional opportunities to provide feedback as MMCO continues to develop and implement these provisions. The comments below are based on our experience working with Medicare-Medicaid Plans in the Financial Alignment Initiative, as well as input we received from advocates in some states with large D-SNP enrollment. We expect to continue to hear more from advocates in the field and continue our own analysis, and so we will continue to share more specific recommendations.

Our comments are organized around the two major issues in the Request, unified appeals and requirements for integration. Within those categories, we structured our comments around primary areas of beneficiary concern, paying particular attention to the topics identified in the request for stakeholder input.

## 1. UNIFIED GRIEVANCE AND APPEALS PROCESSES

We are mindful of the fact that MMCO is required to develop a unified appeal system within two years, a short timeframe to implement a very complex process. Our comments, therefore, are focused on the

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aspects of a unified system that we believe should be prioritized and our reasoning for that prioritization.

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

As beneficiary advocates, we are focusing our comments on how these processes can improve beneficiary experiences, keeping in mind the potential administrative burden for plans and providers.

#### *Overlap and supplemental services*

As we think of a unified appeals system in the D-SNP context, we note that the primary value of a unified process for the beneficiary is for appealing overlap services such as Durable Medical Equipment (DME), home health, and skilled nursing facility care. That single route should also cover supplemental services provided by a D-SNP, particularly because such services may complement or overlap with Medicaid services as well. For example, a D-SNP may provide more comprehensive services or alternative oral health coverage compared to Medicaid. In all these instances, having a single appeal route, at least at the plan level, with unified internal processes, unified timeframes, a unified notice, etc. would improve beneficiary experience.

As discussed more fully in our comments regarding benefits pending appeal, we emphasize the importance of providing full appeal rights with respect to supplemental services.

#### *Medicare-only and Medicaid-only services:*

In instances where a service is covered solely by Medicare or Medicaid, the most important factor for beneficiaries is ensuring a no-wrong-door approach for appeals. D-SNPs should be responsible for assisting the beneficiary to determine the appropriate appeal route, regardless of the payer source. Then, even if separate appeal routes remained in place, the beneficiary would experience a unified process for filing the initial appeal and receive assistance with navigating the appeal process.

For beneficiaries enrolled in a D-SNP with no matching Medicaid Managed Care plan (MCO), i.e., beneficiaries enrolled either in fee-for-service (FFS) or a different sponsor's MCO, the D-SNP should be required to have procedures in place and staff assigned to shepherd a beneficiary who brings a complaint or appeal issue about Medicaid services through the proper route. The PACE program serves as a model here, requiring PACE to assist the participant in choosing which appeal route to appeal if both are applicable.<sup>1</sup>

For all D-SNP members, whether in matching MCOs or not, it is important that the D-SNP establish procedures to assist the beneficiary in obtaining the medical or other documentation needed for the appeal from D-SNP providers. What is most important is that the beneficiary has the help he or she

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<sup>1</sup> Programs of All-Inclusive Care for the Elderly (PACE) Manual, Chapter 11 – Grievances and Appeals, at 20.4, available at [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019036.html](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019036.html).

needs to navigate the appeal, including help in understanding the procedures (which requires that D-SNP personnel understand those procedures) and in addressing the substance of an appeal.

- **Areas where current plan-level Medicare and Medicaid grievance and appeal processes differ and which processes are more protective of the enrollee**

### *Terminology*

There are initial differences in terminology that can easily confuse beneficiaries and need to be addressed. In Medicaid, the term “complaint” refers to what, in Medicare, is a “grievance.” In Medicaid, a “grievance” is an appealable denial of services or coverage, which is called an “appeal” in Medicare. In a unified system, there should be a single set of terms. Because “grievance” is the common term that is likely to cause the most confusion, we suggest eliminating that term and using “appeal” for a denial of services or payment and “complaint” for other concerns such as quality of service, timeliness, etc.

- **Any differences between Medicare and Medicaid, and suggestions for addressing them:**

### *Expedited appeals procedures*

The Request already notes that timelines for expedited appeals may differ between Medicare and Medicaid. Besides timelines, the required showing to trigger expedition may also differ. In Medicare Part C and D, appeals are automatically expedited if the physician indicates that the life or health of the enrollee, or the enrollee’s ability to regain maximum function could be seriously jeopardized by applying the standard time frame in processing an appeal.<sup>2</sup> No additional showing is required. Our understanding is that the standard in at least some Medicaid programs may differ and that the physician’s statement alone may not suffice. There may be other instances where Medicaid programs allow a beneficiary to seek an expedited appeal without the need for physician input. In all cases, the most beneficial standard should prevail in a unified appeals process.

### *How an appeal is initiated*

In many states, beneficiaries in an MCO can begin an appeal with a phone call, which is an important beneficiary protection. Advocates report, however, that the classification of these calls often gets, in the words of one advocate, “squishy.” MCOs are reluctant to classify such calls as appeals or fail to instruct the beneficiary to make a required written appeal. Instead the beneficiary is promised that the plan “will look into” the issue. Part of the MCOs’ motivation, it appears, is to limit the number of appeals that must be reported. The result, however, is that a formal appeal is not initiated, the clock does not start, and the beneficiary has no clear expectation of when or if a concern will be resolved.

We note that the Medicare program has had similar issues, primarily in the context of plans classifying issues as grievances (“complaints” in Medicaid terminology) when they should have been identified as appeals. CMS has responded to the problem by issuing increasingly specific guidance and looking at

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<sup>2</sup> Medicare Managed Care Manual, Ch. 13 at 80.1, available at [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf).

misclassification of complaints in the audit process. It appears to us that, at least with managed care, the Medicare program offers more specificity and oversight in the regulation of complaint classification than Medicaid. In a unified system, it is important that there be maximum clarity so that beneficiaries get timely access to the appeals system and that requests made by phone, through a web portal, in person, or in writing start the processing clock, regardless of who makes the request.

Advocates also note that the CMS Complaint Tracking Module (CTM) has been a helpful tool on the Medicare side in ensuring that plans correctly categorize and resolve problems in a timely fashion. Since D-SNPs are Medicare Advantage plans, we assume that tool will continue to be available. To ensure a no-wrong-door approach for beneficiaries, the CTM system may need to be enhanced so that complaints addressing overlap matters get the same full attention and monitoring by CMS and the state that Medicare-only complaints currently get from CMS. We recommend that any attempt to challenge a denial of services, payment or other adverse action should be treated as the receipt of an appeal for the purposes of starting the processing clock.

#### *Prior Authorization and gathering additional documentation during the appeal process*

If a service or item requires documentation from a provider, such as prior authorization, the forms or instructions generated by the D-SNP should include all information needed to determine coverage under both Medicare and Medicaid. The provider should not have to provide additional information if the D-SNP denies Medicare coverage and a Medicaid review follows. This step, as with several of our recommendations, requires that the D-SNP know the state's Medicaid requirements.

#### *Good cause for late filing*

We urge that CMS review with each state the Medicare and Medicaid standards for good cause for late filing of an appeal or of other steps in the appeal process and ensure that the standard most favorable to the beneficiary is used in that state. Further, the unified appeals process must include a process to provide reasonable accommodations for those who require them due to disability. Such reasonable accommodations may include extensions of time to file appeals.

#### *Effect of a failure of a plan to meet required timeframes*

In Medicare, if a Medicare Advantage plan fails to meet the timeframe for its internal review, the plan must forward all information to the Independent Review Entity (IRE).<sup>3</sup> Further, if CMS determines that a plan has a pattern of such failures, the plan will be considered to be in breach of its Medicare contract. As a baseline, we suggest that the same standards apply here (if the timeline is not met, the appeal should automatically proceed to the next level of the process, and a pattern of failures is a breach of the Medicare or three-way contract), unless the Medicaid standard is more beneficial to plan members. We urge that CMS and states review their respective rules on such failures on the part of the plan and ensure that D-SNPs are held to the standard that is most beneficial to plan members.

#### *Language and disability access*

As is required in the dual eligible demonstration three-way contracts, the translation and interpretation requirements most favorable to the beneficiary should be adopted in any unified appeal system. We

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<sup>3</sup> See Medicare Managed Care Manual, Ch. 13 at 70.7.4.

expect that in almost all cases the state standard would be more favorable since, currently, CMS does not require translation of any appeals documents. We also note that D-SNPs have language access obligations under Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act that are independent of those imposed by CMS or the state. Accommodations at hearing for persons with disabilities also must be robust and fully consistent with state and federal requirements.

#### *Amount in controversy*

Medicare requires that a financial threshold be met in order to pursue an appeal at the Administrative law Judge (ALJ) level and federal district court level. Most state Medicaid programs have no such threshold requirements. The Medicaid standard is better for the beneficiary and should be the one adopted – no financial threshold should be required.

- **Options for unifying and simplifying the appeals process beyond the plan level that preserve the beneficiary protections contained in both Medicare and Medicaid procedures**

The experience of the Fully Integrated Duals Advantage (FIDA) model in the New York financial alignment demonstration deserves study.<sup>4</sup> In addition, we raise two pieces to be considered in a larger scheme.

#### *Discovery rights at hearing*

State Medicaid agencies are required to give the applicant or recipient, prior to and during the hearing, an opportunity to examine the case file as well as all documents and records the agency intends to use at the hearing.<sup>5</sup> Many states provide discovery rights in accordance with state fair hearing procedures. Those rights are not automatic in Medicare hearings. The procedures most favorable to the beneficiary should be used.

#### *Waiver of copying charges*

At all levels of a uniform appeals system, state Medicaid programs, MCOs, D-SNPs, and Medicare should be required to waive all copying charges on both the Medicare and Medicaid sides related to an appeal by a dual eligible.

- **Considerations in applying benefits pending appeal to all benefits under Medicare Part A and B, and Medicaid, such as applicability to supplemental benefits, and how to integrate benefits pending rules with existing Medicare fast-track appeals requirements for certain services**

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<sup>4</sup> See Center for Health Care Strategies, Integrated Appeals Processes for Medicare-Medicaid Enrollees: Lessons from States (Dec. 2014) (“Integrated Appeals Processes”), available at [www.chcs.org/media/INSIDE-Integrated-Appeals-Processes.pdf](http://www.chcs.org/media/INSIDE-Integrated-Appeals-Processes.pdf).

<sup>5</sup> 42 C.F.R. 431.242(a).

### *Supplemental benefits*

Benefits provided as supplemental benefits through D-SNPs should be subject to the same rules regarding benefits pending appeal as other forms of benefits. Once the benefits are initiated, they should be extended pending the resolution of an appeal.

Ensuring that supplemental services are appealable addresses multiple concerns:

- Due process: If supplemental services are offered by a D-SNP, all beneficiaries should have the right to show that they are appropriate recipients.
- Clarity: Exempting one category of services from the appeals process creates confusion for beneficiaries.
- Person-centered principles: it is difficult to describe a D-SNP design as person-centered if plan members who request services do not have an avenue to appeal denial to those services.
- Discrimination: without an appeals process and the data developed from it, it is difficult for state and federal regulators to determine if supplemental benefits are being authorized in a non-discriminatory way.

### *Integration with Medicare fast-track*

We do not believe that the current limited Medicare fast-track system alone satisfies the statutory requirement for benefits pending appeal in Medicare. The statute recognizes that dual eligibles, with essentially no resources and thus no option to self-pay during an appeal, need the protection of benefits pending appeal, not simply the 24 or 48 hours that those benefits might be extended under the fast-track procedure. Having said that, the fast-track certainly has value. Given the high risk and high stress surrounding a potentially premature discharge from a hospital or skilled nursing facility, it is a beneficiary protection to have more direct access to an independent decision-maker and we recommend its retention. However, the extension of benefits under current Medicare rules is extremely limited, usually only one extra day, which is inconsistent with the new statute. In order to implement the new statutory protections to benefits pending appeal, CMS also must ensure that beneficiaries using hospital, skilled nursing facility, and home health access have the same full rights to continuation pending appeal as all other covered services. As a practical matter, since the D-SNP is the party ensuring that appropriate post-discharge services are in place, the D-SNP has the means to prevent many of the problems that often trigger discharge appeals, such as inadequate services and supports to allow an individual to return safely to home. Thus the burden on a D-SNP that is performing its functions well should not be excessive.

- **To what extent enrollees should be provided with a notice when an item or service is not covered by Medicare but is covered by the plan's companion Medicaid benefit.**

Enrollees should be provided with a notice that clearly indicates that the item or service will be provided through the Medicaid program. If the approval has any impact on the supplier or provider networks that the beneficiary can use or on any aspect of utilization, that should be spelled out in the notice. Because a beneficiary may still wish to appeal the non-coverage through the Medicare program, the appeal process should still be available and mentioned in the notice; however, it is more important that the notice make clear what *will* be provided. One possible approach would be to keep the approval letter

template very simple and also create a Q&A factsheet on what it means when a request is denied under Medicare but approved under Medicaid. The factsheet could be included with the letter and/or provided to beneficiaries who call with questions. The letter also must provide a contact point for questions. D-SNPs need to have very good scripts and knowledgeable representatives to handle those questions. Consumer testing will be critical to determine whether the notice is effective.

In making these comments we recognize that in Minnesota's MSHO integrated D-SNP, an approval notice for Medicaid coverage of an overlap service does not mention the Medicare denial.<sup>6</sup> However, since many D-SNPs are not as integrated as Minnesota, either in services or in provider payment procedures, we think that both the beneficiary and the provider need some notice of the Medicare denial. That notice is particularly important if the Medicare denial impacts the beneficiary's provider choices.

- **To what extent enrollees should be required to provide written consent when someone other than the enrollee (provider, relative, other person) is requesting an appeal:**

Consent requirements protect the rights and autonomy of beneficiaries. In the context of an appeal of the denial of services that a provider has prescribed, the threat to a beneficiary's rights or autonomy in allowing others to pursue a timely appeal, particularly at the initial stages, appears minimal. In Medicare Part D, for example, we have not heard of any problems or abuses arising from the provision that allows a prescriber to request a standard or expedited coverage determination, redetermination, or IRE reconsideration on an enrollee's behalf without being a representative and without written authorization from the beneficiary.<sup>7</sup> We urge that a treating provider or prescriber for any D-SNP service be permitted to pursue an appeal through at least the first external level of appeal without a requirement for written or verbal consent. The advantages of access to services by extending this right to other persons, such as a family member or legal services provider, also seem to outweigh the risks, particularly if safeguards are included such as written notice to the beneficiary that the appeal has been initiated on the beneficiary's behalf and, in all cases, a right of the beneficiary to take control of the appeal at any time.

We have witnessed the disadvantages when there is a delay or an inability to appoint a representative to make important decisions. For example, in the context of enrollment in the California demonstration, there was no avenue for SSI beneficiaries to file a power of attorney to allow a representative to make plan enrollment choices. For SSI beneficiaries whose health or mental capacity limited their ability to manage their own affairs, this stumbling block led to severe problems in access to care. In response, California created an "Enrollment Assistant" designation that allowed an individual other than the beneficiary to make an enrollment decision after attesting to their authority and absence of a conflict of interest.<sup>8</sup> The process included a number of beneficiary protections including sending a notice regarding

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<sup>6</sup> See Integrated Appeals Processes, *supra* note 4, p. 3.

<sup>7</sup> Medicare Prescription Drug Benefit Manual, Ch. 18 at 10.4.2 and 10.5, available at [www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html](http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html).

<sup>8</sup> See Designating an "Enrollment Assistant" to Represent Medi-Cal Beneficiaries with their Enrollment Decisions, available at [http://calduals.org/wp-content/uploads/2015/09/Cal-MediConnect-Enrollment-Assistants\\_REVISED-VERSION.pdf](http://calduals.org/wp-content/uploads/2015/09/Cal-MediConnect-Enrollment-Assistants_REVISED-VERSION.pdf).

the enrollment transaction to the beneficiary with the option to change the enrollment decision and archiving the attestation call. To date, there has been no indication that this process has been abused.

In appeals, the problems are similar for beneficiaries who have temporary or permanent diminished capacity or who are otherwise unable to provide consent but have no power of attorney or guardianship in place. They are effectively blocked from any appeal rights. The appeals process can include the appointment of an appeal representative for a beneficiary who has diminished capacity if needed, but no external process (such as guardianship) should be required.

- **Use of other modalities to request an appeal such as orally and through an Internet website:**

We recommend that any attempt to file an appeal, including requests made by phone, through a web portal, in person, or in writing, be permissible. An appeal received through any modality should be treated as the receipt of an appeal for the purposes of starting the processing clock. The plan should be responsible for memorializing any oral request (received by phone or in person) into writing, if needed for the plan's appeal processes. Appeal forms should be available but, as with Medicare Advantage currently, not required.

## **2. REQUIREMENTS FOR INTEGRATION**

We urge CMS to consider the following as guiding principles when developing integration standards for D-SNPs:

- Beneficiaries must have access to all providers and services they need in both Medicare and Medicaid. They need robust provider networks and help in accessing those networks.
- Beneficiaries need stability. They need care continuity when they first join a D-SNP. They should not be disenrolled because of resolvable eligibility issues or changes in their health.
- Beneficiaries need concrete and effective assistance in accessing both their Medicaid benefits and other community services that will assist them to live in the community.
- Beneficiaries need person-centered, culturally competent care that empowers them to control their own health choices as much as possible.

With those principles in mind, we have the following comments to the questions raised in the Request:

- **Subsection (D)(i)(1) lists examples of potential requirements for integration. We welcome comment related to those examples.**

There are three examples in the statute. Our comments on each follow:

*Notifying the state in a timely manner of hospitalizations, emergency room visits, and hospital or nursing home discharges of enrollees.*

The requirement to notify the state in a timely manner of hospitalizations, emergency room visits, and hospital or nursing home discharges of enrollees is necessary, but insufficient. Contracts should include much more detailed protocols for how the D-SNP will ensure timely access to needed Medicaid-funded follow-up services. In addition, they should specifically address how the D-SNP will coordinate with the Medicaid program to meet *Olmstead* requirements for the provision of care in the least restrictive environment.

In a delivery system where the dual eligible is enrolled in a Medicaid plan that is responsible for LTSS, informing the plan of these changes could lead to better coordination and access to services. In situations, however, where the dual eligible is not enrolled in a Medicaid plan but instead is in fee-for-service Medicaid or in a Medicaid plan not responsible for LTSS, there is no entity responsible on the Medicaid side for connecting the dual eligible to needed LTSS services. Since fee-for-service Medicaid does not have caseworkers coordinating care, we question whether any action would be taken with data sent to the state about discharges. The D-SNP must do more than send information to a state computer. It must take steps to ensure that the D-SNP member is connected with needed Medicaid services and, as appropriate, is evaluated for HCBS or other available services.

Even in the financial alignment demonstrations, where one plan holds all the data, we continue to see problems in linking beneficiaries to follow-up Medicaid services when they are discharged. Hospitals have indicated that when they attempt to discharge a dual back into the community or to a skilled nursing facility, the health plan is not assisting with the discharge. In theory, since the demonstration plan is contracted with the MLTSS providers, the plan should be facilitating the discharge. Yet, this is not occurring. It will be more challenging for a D-SNP that is not contracted with the MLTSS providers to facilitate the best discharge situation. But merely sharing the hospitalization data is insufficient and does not constitute coordination of services.

We urge that contracts include a very specific list of care coordination responsibilities for a D-SNP when a member is discharged. California's guidance for MMPs on hospital discharge planning could serve as a model.<sup>9</sup> In discharge planning the MMP is required to set up services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community-based LTSS programs; coordinate care, as appropriate with the beneficiary's caregiver, other agencies and knowledgeable personnel, as well as ensure the beneficiary's care coordinator contact information is readily available to hospital staff; and provide the beneficiary with necessary information for making follow-up appointments.

*Assigning one primary care provider to each enrollee.*

Without question, all D-SNP members should have a primary care provider (PCP), and the D-SNP should assist the beneficiary in making that choice. The beneficiary should have the opportunity to choose the provider of her choice and to change providers at any time.

Importantly, choice of primary care provider should not in any way limit the access that the beneficiary has to the full provider network of the D-SNP. Particularly in the California financial alignment demonstrations, we have seen use of a delegated network model. In that model, once a beneficiary has a PCP, the beneficiary is limited to other providers within the delegated entity to which the PCP belongs. If the beneficiary wishes to use an out-of-delegated-network provider, a specialist for example, the beneficiary must change to another PCP who is in the same delegated network as the specialist. This approach does not work for beneficiaries with high needs. All D-SNP members should have full access to

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<sup>9</sup> Discharge Planning for Cal MediConnect (DPL 16-003) (July 2016), available at [www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2016/DPL16-003.pdf](http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2016/DPL16-003.pdf). See also, Cal MediConnect Hospital Case Managers Toolkit, (Oct. 2016), available at [http://calduals.org/wp-content/uploads/2016/10/Case-Manager-Toolkit\\_-10\\_20\\_16\\_FINAL.pdf](http://calduals.org/wp-content/uploads/2016/10/Case-Manager-Toolkit_-10_20_16_FINAL.pdf).

all providers in the plan's network and should not have to disrupt their relationship with a trusted PCP to access an in-network specialized provider of their choice. The delegation model also has led to many other problems in provider billing, data collection, and referral.<sup>10</sup> Delegated networks should not be permitted in D-SNPs.

*Sharing data that would benefit the coordination of items and services.*

Sharing data is an essential predicate to coordinating care. Integration with state Medicaid programs requires exchange of many types of data: enrollment and eligibility data, claims data, encounter data and more. That exchange only works if plans have computer systems in place that interface effectively and reliably with:

- CMS
- state systems
- if the state delivers Medicaid benefits through managed care plans, with those plans
- In states that adopted Expansion Medicaid, with the Medicaid plans from which individuals will be moving once they attain Medicare eligibility.

Rigorous testing: The experience of the financial alignment demonstrations has shown that many of the initial problems for beneficiaries resulted from data interface deficiencies. Before permitting any D-SNP to operate, both the state and CMS should ensure through rigorous testing that a D-SNP's systems can handle all functions effectively. It should be noted that in the financial alignment demonstrations, integration of systems took far longer than anticipated and required more extensive financial investments from states and plans than estimated.<sup>11</sup>

Other entities: Effective integration can require data coordination with other entities beyond CMS, the state and MCOs. In carve-out situations it may be necessary to put in place data transfer agreements with LTSS, behavioral health and other provider entities, either directly or through intermediate agencies. For example, the California IHSS program is administered at the county level. Behavioral health is a carve-out and administered by county health plans (this is common across states). Medicaid oral health benefits also are frequently carved out from MCOs. In Florida, for example, oral health had been incorporated into MCO coverage but the state is now planning to carve it out again, using separate dental managed care plans. For effective integration and care coordination, D-SNPs will need to have MOUs or other contractual relationships with the entities delivering these carved out services.

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<sup>10</sup> The SCAN Foundation, Integration of Medicare and Medicaid in California: Provider Perspectives of Cal MediConnect (January 2018), available at [www.thescanfoundation.org/sites/default/files/provider\\_perspectives\\_final\\_010818.pdf](http://www.thescanfoundation.org/sites/default/files/provider_perspectives_final_010818.pdf). Relatedly, Minnesota's MSHO program also found that integration of coverage determinations and payments was more challenging when a health plan delegates service authorizations for claims payment to a contracted entity. See Integrated Appeals Processes, *supra* note 4, p. 5.

<sup>11</sup> RTI International, Report on Early Implementation of Demonstrations under the Financial Alignment Initiative (Oct. 2015) available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf).

Recommendations to facilitate sharing have included standardizing reporting procedures and forms and designating plan liaisons for the various LTSS providers and plans so that there is one person to contact for data sharing.<sup>12</sup> Functionality will need to be fully tested.

Real time sharing of critical health information: There also should be requirements for D-SNPs to have systems to facilitate information flow from LTSS providers to the D-SNP. Day centers and home health aides, for example, may be the first to notice significant health changes. There should be protocols that allow appropriate sharing of information, with necessary privacy protections, to ensure that the D-SNP promptly learns of potential needs for Medicare covered services, particularly for individuals who lack family assistance or the ability to self-report. Likewise, there should be protocols in place that facilitate D-SNPs sharing critical health information with LTSS providers. In California, there have been obstacles in the sharing between MMPs and LTSS providers.

- **Other than those explicitly mentioned in subsection (D)(i)(1), additional D-SNP activities CMS should consider requiring as integration standards in the state Medicaid agency contracts to meet the requirements of subsection (D)(1)(i).**

Required integration standards should address:

#### *Access to Medicaid services*

States provide Medicaid services, including LTSS services, to their dual eligible populations through fee-for-service models, managed care models or combinations, often with carve-outs. Today D-SNPs operate in these different milieus and subsection (D)(i)(1) appears to envision them continuing to do so. The presumed value of D-SNP membership in such mixed environments would include coordination of care and benefits across programs, no matter the delivery mechanism. We agree that D-SNPs should not be limited to environments where the dual eligible is enrolled in Medicaid managed care, and there should be mechanisms for coordination in all models.

A foundational requirement for D-SNPs, however, must be that D-SNP members be able to access needed Medicaid services without having to disenroll from the D-SNP. CMS should not authorize D-SNPs when membership only works if the member doesn't need substantial Medicaid services.

Currently we see a disconnect in Florida. Florida has the largest number of D-SNP enrollees, over 300,000.<sup>13</sup> Florida's approach to D-SNPs is the opposite of integration:

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<sup>12</sup>C. Graham, et al, Provision of Home- and Community-Based Services through Cal MediConnect Health Plans, (Nov. 2017), available at [www.thescanfoundation.org/sites/default/files/ucb\\_researchbrief\\_hcbs\\_final.pdf](http://www.thescanfoundation.org/sites/default/files/ucb_researchbrief_hcbs_final.pdf).

<sup>13</sup> Integrated Care Resource Center, New and Departing Dual Eligible Special Needs Plans (D-SNPs) in Calendar Year 2018 by State, available at [www.integratedcareresourcecenter.com/PDFs/D-SNP\\_CY%202018%20by%20State.pdf](http://www.integratedcareresourcecenter.com/PDFs/D-SNP_CY%202018%20by%20State.pdf).

- Although Florida mandatorily enrolls other dual eligibles in MCOs, the state excludes D-SNP enrollees from MCO enrollment. D-SNP members are not mandatorily enrolled and cannot voluntarily enroll in an MCO.<sup>14</sup> They get Medicaid services through FFS.
- Further, the only way for a dual eligible to receive LTSS is through waiver services provided by an LTSS MCO. To get LTSS services, the dual enrolled in a D-SNP must disenroll from the D-SNP. From the Florida SHINE program (its SHIP), we were told that a common occurrence is that an individual enrolls in an LTSS MCO for needed services without first disenrolling from the D-SNP, then is automatically disenrolled from the D-SNP and receives a letter telling him that the disenrollment is because “your Medicaid coverage has changed.”

We have serious concerns that Florida, the largest D-SNP state in the nation, appears to have procedures that frustrate the purpose of the D-SNP model. Florida advocates report that, while dual eligibles with stable health can fare well enough in D-SNPs, if their health deteriorates and they need LTSS, they experience disruption in their care network and confusion at the very time when they most need care coordination. This model does not make sense to us. Beneficiaries in D-SNPs need stable systems of care. They should not have to experience care disruption when their health and LTSS needs increase.

Advocates also have observed more generally that that beneficiaries who become sicker or are admitted to a nursing facility frequently disenroll from Medicare Advantage plans, including D-SNPs, because the plans are not meeting the needs of these individuals. Even in the duals demonstrations, the composition is predominantly community well.<sup>15</sup> Problems exist beyond the structural impediments found in Florida, including inadequate and unresponsive networks that make it difficult for beneficiaries to stay in D-SNPs. D-SNPs should not be able to claim that they are doing coordination when most of their members do not need coordination because they are the healthy segment – and D-SNPs are serving healthy people because they cannot meet the needs of those who are sicker.

### *Matching MCO*

In states that require MCO membership for dual eligibles, we question allowing D-SNPs to operate if they do not offer a matching MCO. Pennsylvania advocates report that in Allegheny County there are eight D-SNPs, only three of which have matching MCOs. Individuals in the five D-SNPs without MCOs operated by the same sponsor are forced into a situation where they are dealing with two plan sponsors. We do not see this as promoting integration.

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<sup>14</sup> Fla. Dep’t for Healthcare Administration, Coordinating Dual Eligibles’ Medicare and Medicaid Managed Medical Assistance Benefits, *available at* [https://ahca.myflorida.com/medicaid/statewide\\_mc/pdf/mma/Coordinating\\_Dual\\_Eligibles\\_Benefits\\_White\\_Paper\\_Revised\\_2015-08-14.pdf](https://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Coordinating_Dual_Eligibles_Benefits_White_Paper_Revised_2015-08-14.pdf). The exclusion described in this FDHA document is consistent with what advocates describe as how enrollment works on the ground. We note however that Florida’s Medicaid managed care waiver does not mention any exclusion of D-SNP members. See [www.fdhc.state.fl.us/medicaid/Policy\\_and\\_Quality/Policy/federal\\_authorities/federal\\_waivers/docs/FL\\_1115\\_MA\\_Waiver\\_Extension\\_Request.pdf](http://www.fdhc.state.fl.us/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/FL_1115_MA_Waiver_Extension_Request.pdf). We also note that Florida has one set of D-SNPs, operated by Freedom, Inc., in which approximately 38,000 dual eligible are members. Those D-SNPs enroll duals who also have certain specified chronic conditions and (we think) have matching MCOs, though we are unclear whether LTSS services are available from those MCOs.

<sup>15</sup> For example, at a stakeholder meeting, one large California demonstration plan reported that its membership was 70% community well.

We do not argue that D-SNP members should always be required to enroll in a matching MCO, since we hear from advocates that some beneficiaries, primarily for reasons of network access, do better in non-matching plans. But we do think that a dual eligible who is required to be in an MCO should at least have the option of one operated by the D-SNP to which she belongs. Also, as a practical matter, advocates report that D-SNPs run by sponsors that only offer Medicare products demonstrate a poor understanding of Medicaid and thus tend to be ineffective in coordinating benefits.

### *Partial duals*

We have concerns about whether, under subsection (D)(i), D-SNPs that enroll individuals who are partial duals—those who qualify for a Medicare Savings Program but do not qualify for full-scope Medicaid benefits—should continue. Since MSP-only beneficiaries do not have coverage for Medicaid services, there is nothing for them to integrate or coordinate. We question how a D-SNP could fulfill any of the integration requirements of a state contract for its MSP-only members. We understand that most of the D-SNP enrollment in New York State consists of partial dual eligibles. Advocates report those beneficiaries get little value from those plans that is not available from other Medicare Advantage products. Our own speculation is that D-SNPs may have been somewhat helpful to QMB-onlys because they were less likely to encounter improper billing with D-SNP providers. However, because CMS has taken significant steps to ensure that all Medicare Advantage plans protect their QMB members from billing, that possible advantage should have lessened.

### *Enrollment stability when Medicaid enrollment lapses*

Advocates report that beneficiaries face significant disruptions in care when they are disenrolled from a D-SNP because of loss of Medicaid eligibility. In most cases, the problem with Medicaid recertification is ultimately resolved within a couple of months, but the beneficiary then faces hurdles in getting re-enrolled in the D-SNP and many access problems in the interim. It is important that contract requirements with states address this issue. We propose two alternatives:

- In several of the financial alignment demonstrations, there is a “deeming period”—it is three months in California—when plans can retain enrollees while their Medicaid enrollment issues are sorted out. Although the deeming period is optional for plans in the demonstrations, we propose that it be required for D-SNPs. Because they are not administering Medicaid benefits, D-SNPs do not have the potential financial liability that demonstration plans have in those rare cases where Medicaid ineligibility is permanent. A mandatory provision providing for at least three months of deeming is appropriate.
- An even simpler approach would be to align D-SNP disenrollment policies with Low Income Subsidy (LIS) disenrollment policies. That coordinated approach would mean that the individual losing Medicaid eligibility could stay in the D-SNP until the end of the plan year. If the Medicaid loss of eligibility happened in the second half of the year, the individual could stay in the D-SNP until the end of the following plan year. For the small percentage of individuals who permanently lose Medicaid eligibility, this approach would allow time for an orderly change to Medicare Advantage or fee-for-service Medicare on a timetable that could be aligned with potential change in Part D payment liability.

### *Transition policies*

Continuity of care is essential for dual eligibles. New D-SNP members need time for an orderly transition to in-network providers in order to prevent disruption in care. We recommend that state contracts include a transition period of at least six months, which was the period used in most of the financial alignment demonstrations. As was learned in the demonstrations, it is important that the details of the transition policy be clearly explained to providers and that out-of-network providers have easy routes to getting paid. It was also learned that it is important to communicate continuity of care protections to beneficiaries.<sup>16</sup>

We note that many D-SNP members who are new to Medicare may be enrolled in D-SNPs through streamlined enrollment from expansion Medicaid coverage under procedures allowed in the newly-adopted Part C regulations.<sup>17</sup> They especially need to have access to their previous Medicaid physicians, DME suppliers and other providers, even if out-of-network, while adjusting to their new D-SNP. These protections should be part of the D-SNP's state contract.<sup>18</sup>

### *Minimum Medicaid training and competency requirements for D-SNP care coordinators*

Care planning and care coordination, including coordination with Medicaid services, are central to a D-SNP model. To be effective, D-SNP care coordinators need a thorough understanding of what services are covered under the state Medicaid benefit, how the delivery system is designed (FFS, MCOs, carve-outs, etc.), and what steps an individual must take to access those benefits. Contracts should require care coordinators to demonstrate those competencies. Further, care coordinators should be required to demonstrate an understanding of non-Medicaid community resources (Meals on Wheels, SNAP, subsidized housing, energy and phone subsidy programs, senior centers, Alzheimer's Association resources, etc.) available in the communities served by the D-SNP and how to access those services.

### *Training of in-network providers on Medicaid benefits*

Medicare providers in the D-SNP need at least some basic knowledge of Medicaid benefits available to D-SNP members. Without such knowledge, they may fail to prescribe needed services that could be covered by Medicaid. Contracts should include a requirement that plans establish outreach initiatives to improve the knowledge base of their providers on the Medicaid benefit. The Rhode Island three-way

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<sup>16</sup> Beneficiary Experience: Early Findings from Focus Groups with Enrollees Participating in the Financial Alignment Initiative, (Mar. 2017), available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf).

<sup>17</sup> The final rule with commentary is scheduled to be published in the April 16, 2018 Federal Register.

<sup>18</sup> *Id.* We note that in the commentary to its adoption of new section 42 C.F.R. 422.66(d), CMS stated that the agency does not have statutory authority to impose a transition requirement on D-SNPs. That federal concern should not constrain states from including such protections in their contracts.

contract for the state’s financial alignment demonstration, which includes a comprehensive list of training topics on Medicare and Medicaid for providers offers a good model to start from.<sup>19</sup>

### *Person-centered care coordination*

Contracts should set out specific requirements for person-centered care coordination including:

- Incorporation of potential LTSS needs in the Health Risk Assessment and care plan
- Adherence to *Olmstead* principles and coordination with Medicaid to ensure that Medicare and Medicaid providers are working together to deliver services that enhance personal autonomy and allow the beneficiary to live in the least restrictive setting.<sup>20</sup>
- Ensuring that D-SNP managed care policies support, rather than interfere with, beneficiaries who self-direct, or wish to self-direct their Medicaid services.

### *Beneficiary education*

Advocates report to us that they see beneficiaries who are in D-SNPs and have not received help from the D-SNP when they ran into difficulties navigating their Medicaid benefits. In some cases, they sought assistance and did not get it. In other cases, however, beneficiaries had no idea that their D-SNP was supposed to assist in coordinating their benefits and never thought to ask for help. To address the need for beneficiary understanding of the D-SNP’s role, we urge that contracts include provisions requiring that Welcome Calls, Health Risk Assessments, and Care Management contacts with beneficiaries specifically include discussions explaining to beneficiaries how and to what extent the D-SNP integrates services and what specific assistance the beneficiary can ask of the D-SNP. This information should be in the Summary of Benefits and the Evidence of Coverage, but beneficiaries also need personalized explanations if a D-SNP is to be effective in its mission.

### *Enrollment of D-SNP providers in Medicaid*

To facilitate integration of services, it is ideal if all D-SNP providers are also enrolled Medicaid providers. Nevertheless, particularly with specialists and particularly in rural areas, it may not be possible for a D-SNP to achieve this goal and still have a network that is adequate. However, when an in-network provider is not enrolled in Medicaid, at least as an “ordering, referring or prescribing” provider, dual eligible plan members may not be able to access Medicaid services prescribed by that provider.

Systems should be in place to address this problem. One option would be for the state and the D-SNP to develop procedures whereby any provider that meets the plan’s credentialing requirements will be

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<sup>19</sup> See Rhode Island Three-Way Contract (“RI Three-Way”) at 2.7.6 (p. 127 et seq.), available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/RIContract01012018.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/RIContract01012018.pdf).

<sup>20</sup> See *id.* at 2.6.6 for an example of some elements of a care plan that should be spelled out to ensure that planning is person-centered and takes into account needs for services beyond those covered by Medicare that may not be covered directly by the D-SNP.

automatically enrolled in the Medicaid program as an ordering, referring or prescribing provider. This might require some modification to a plan's credentialing procedures but would have the benefit of eliminating the need for providers to independently enroll. Another alternative is for the plan to require that in-network providers enroll at least as ordering, referring, or prescribing providers and assist its providers with the enrollment process.

#### *Incorporating FQHPs and RHPs into D-SNP networks*

We also ask that, absent good reasons, D-SNPs be required to include in their network all Federally Qualified Health Plans (FQHPs) and Rural Health Plans (RHPs) in their service areas. FQHPs and RHPs usually co-locate Medicare and Medicaid-covered services and are attuned to the needs of dual eligibles. It is likely that many new D-SNP members already have established relationships with FQHP and RHP providers that were established before the beneficiary became eligible for Medicare.

#### *DME access*

Advocates report that lack of provider interface across Medicare and Medicaid causes particular problems for dual eligibles trying to access durable medical equipment (DME). Pennsylvania advocates, for example, report that some D-SNP sponsors have highly concentrated DME supplier networks (one or two only) making access even more difficult than in the already constrained Competitive Bidding Supplier universe available to those in FFS Medicare. To make matters more difficult, those very limited suppliers often do not participate in Medicaid, so D-SNP members are left to navigate two sets of suppliers, often with little assistance from their D-SNP. Because DME is the area where Medicare-Medicaid overlap and access issues seem to be the most troublesome, we ask that contracts require that all D-SNP DME suppliers also must be enrolled in the state Medicaid system.

We also ask more generally that both CMS and the state pay particular attention to D-SNP network adequacy for DME. Advocates report that, leaving aside authorization complexities, simply finding a supplier is very challenging on both the Medicare and Medicaid sides. One advocate noted that it is not uncommon for the closest supplier for a piece of specialized equipment to be 100 miles away.

#### *NEMT coordination*

Another area of persistent problems is coordination with the Non-Emergency Medical Transportation (NEMT) benefit. Contracts should specifically require that care coordinators assist beneficiaries in arranging NEMT and ensure that any required certification of need by a plan Medicare provider is obtained.

#### *Language and disability access*

We urge that D-SNPs be required to provide dual eligibles with language and disability access in compliance with the requirements most favorable to the beneficiary. Some states, for example, have translation requirements for documents that are more extensive than those found in Medicare. A

beneficiary who is receiving language concordant communications about her Medicaid benefits should not be forced to struggle with English language communications on the Medicare side. Similar principles should apply for alternate formats and other disability accommodations. More specifically, we also ask that contracts provide additional details on language and disability access rules for marketing, outreach and enrollee communication materials (including appeals). The Rhode Island three-way contract provides an example that adds, among other requirements, a mandate to achieve a Flesch Score of 40 or better, which approximates a sixth-grade reading level.<sup>21</sup>

Further, CMS should ensure that plan networks meet the needs of their limited English proficient members and their members with disabilities.

### *Supplemental benefits*

Supplemental benefits can be a key way to knit together Medicare and Medicaid benefits and fill in the cracks between the two. To do this effectively:

- Benefits should genuinely supplement or complement Medicaid benefits and not simply duplicate them.
- D-SNPs must educate beneficiaries, providers and front-line plan staff about their availability. The Cal MediConnect dual eligible demonstration offers an example of where awareness was inadequate, making access less consistent than it should have been.<sup>22</sup>
- Simply referring someone to a Medicaid benefit or providing a phone number for a community resource, like Meals on Wheels, is not a supplemental benefit. Rather, linking dual eligibles with other services is a *core* responsibility of a D-SNP.
- CMS and states should closely monitor supplemental benefits to determine the extent to which they are actually delivered. In the demonstrations, advocates have observed that few beneficiaries are actually getting supplemental benefits. The limited data available has not refuted that observation.
- As stated in our comments on appeals, it is critically important that supplemental benefits be subject to the appeals process, including both plan appeals and further appeals to the IRE and beyond.

### *Stakeholder Participation*

As with the financial alignment demonstrations, D-SNPs would benefit greatly from consumer councils or other established and regular procedures for plan members to raise issues, provide input and proposals, and generally interact with D-SNP management. We urge that state contracts require D-SNPs to establish and support such councils, including supporting participation by members with disabilities and by those who need language assistance.

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<sup>21</sup> *Id.* at 2.13.2.1., p. 188.; see also, California Three-Way Contract at 2.9.10.8.4, p. 87, available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract01012018.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract01012018.pdf).

<sup>22</sup> Provision of Home- and Community-Based Services through Cal MediConnect Health Plans (Nov. 2017), available at [www.thescanfoundation.org/sites/default/files/ucb\\_researchbrief\\_hcbs\\_final.pdf](http://www.thescanfoundation.org/sites/default/files/ucb_researchbrief_hcbs_final.pdf).

- **Roles states and CMS should play in determining whether D-SNPs meet the integration standards established by the Secretary and continue to meet throughout the contract term.**

Experience with the dual eligible demonstrations has shown that vigorous state and federal oversight will be essential to the success of the D-SNP model.

### *Models of Care*

Federal responsibility for oversight of D-SNP integration should begin with the Model of Care. Although this Request focuses on the design of provisions for D-SNP contracts with states, much of the specific action needed for effective integration with Medicaid services should also be embedded in the Model of Care (MOC) that the D-SNP submits to CMS and that CMS reviews. CMS review and approval of these submissions should be an initial and important part of the agency's oversight role. After sampling several summaries of D-SNP MOCs posted on the CMS website,<sup>23</sup> we believe that CMS should enhance its requirements for MOCs to include more specific discussion of integration requirements. Although our review found some MOC summaries that detailed specific ways in which the D-SNP would integrate HCBS and other Medicaid services into care planning,<sup>24</sup> many did not, including several submitted by sponsors that are large players in the D-SNP market. Those MOC summaries were silent on how clinical care would coordinate with Medicaid services.<sup>25</sup> They made no mention of how HCBS, LTSS, or any Medicaid services would be considered or addressed in Health Risk Assessments, or be incorporated into care plans or interactions with members. The only place where the word "Medicaid" even appeared was to describe beneficiary eligibility criteria.

Although admittedly the MOC summaries are just summaries, it still is concerning that references to coordination with Medicaid services was totally missing. Further, the criteria that CMS now uses to score MOCs also seems woefully deficient in addressing this core mission of D-SNPs, and does not appear to require consideration of integration of care at any level.<sup>26</sup> We ask that CMS consider ways to strengthen the MOC requirements and review process. We also urge that through oversight, CMS ensure that the mechanisms described in a D-SNP's MOC are fully implemented.

### *Contract Management Teams*

We urge that the Contract Management Team (CMT) approach used in the dual eligible demonstration should, with some modification, be used with D-SNPs. Without a unified approach to oversight, plans can play one regulator off against the other, with neither fully understanding the situation nor taking necessary action when issues arise. In the financial alignment demonstrations, the CMT has been considered invaluable by all players. The CMT can resolve issues as they arise, monitors plan compliance

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<sup>23</sup> SNP summaries are available on the SNP MOC Summary page at [www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-Model-Of-Care-Summaries.html](http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-Model-Of-Care-Summaries.html).

<sup>24</sup> See, e.g., *id.* at Contract # H 5425 (Scan Connections at Home) and #H 5823 (Molina Healthcare of Washington).

<sup>25</sup> See, e.g., *id.* at Contract # H 0251 (United HealthCare Dual Complete); #H 1045 (Preferred Medicare Assist); and #H 4279 (UPMC For You Advantage).

<sup>26</sup> A download of the SNP Approval Process is available on the CMS SNP page at [www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNPMOC.html](http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNPMOC.html). When the current review criteria were first proposed, advocates expressed concern that the rating criteria seemed more focused on how the write-up was constructed (e.g., if two examples were provided when three were required) than on the substance of what was proposed. We continue to have those concerns.

with their contracts, responds to beneficiary complaints, coordinates with the ombuds, and reviews grievance and appeals. The CMT also proved valuable in resolving any differences in Medicare and Medicaid policies during implementation.<sup>27</sup>

#### *Multiple enforcement levers*

We also urge that there be a variety of regulatory levers and sanctions available when a D-SNP violates contract provisions or fails to provide required care. For example, in addition to broader sanctions that are based on retrospective review of a plan's overall performance, contracts could include specific per-violation penalties that are issued immediately.

#### *Real time oversight*

We urge that both CMS and the state use secret shopper surveys and similar techniques to determine whether D-SNPs are complying with their obligations. Experience in the financial alignment demonstrations has shown that collection and sorting of annual data can be frustratingly slow and is inadequate for timely determinations of compliance. We also urge use of other techniques developed in the demonstrations such as pulling of care plans in order both to develop best practices and to counsel plans on areas of weakness.

As noted earlier in these comments, 1-800-Medicare and the Medicare Complaint Tracking Module (CTM) should also continue to be avenues for beneficiaries to register complaints and problems. If a beneficiary's call about a D-SNP is related to Medicaid coordination, there should be procedures in place to ensure that the complaint is properly routed to relevant CMS and state regulators. Similarly, states should ensure that complaints raised with state help lines about D-SNPs are correctly routed. The no-wrong-door principle for D-SNPs should apply to CMS and states as well.

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

Our comments on this section are primarily cautionary. We note the challenges to integration created by carve-outs. However, we urge caution in response. While moving carve-outs into MCOs may be the best approach on paper to get fully integrated services, it is important to look closely at the facts on the ground. Advocates in some states report that when behavioral health services were integrated into MCOs, wait times increased significantly and beneficiaries complained about the quality of the network. Behavioral health for persons with serious mental illness is a particularly challenging field in which some county systems have experience that is difficult to duplicate. In the states where behavioral services

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<sup>27</sup> RTI International, Report on Early Implementation of Demonstrations under the Financial Alignment Initiative, (Oct. 2015), available at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf](http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf).

were integrated into the financial alignment demonstrations, the path also has been rocky, particularly where plan sponsors had little experience in the area.<sup>28</sup>

For a beneficiary, integration is only helpful if it brings better access to better services that are easier to navigate. It is important that integration does not degrade or dismantle well-functioning existing delivery systems, particularly for those with highest need. We note that another complicating factor with behavioral health is that, when integration with MCOs has happened, it usually has been limited to those with mild to moderate diagnoses, leaving those with severe diagnoses in more established carved-out systems. Individuals, however, do not necessarily stay with one diagnosis and there can be disruptions in long-established care networks if, for example, a beneficiary whose diagnosis was severe improves and is upgraded to moderate.

Another issue to consider is that, in some jurisdictions, carved-out behavioral service systems, which serve many individuals who are homeless or in danger of homelessness, are closely integrated with housing service providers and work together to bring stability to this high need population. Moving these individuals out of a carved-out behavioral health system into managed care for the sake of integration may, in fact, tear them out of another highly focused integrated system that has significantly more experience in meeting their needs.

We urge that the admitted complications for D-SNP capitation that result from these carve-outs not overshadow the goal of ensuring that the best services, fully integrated or not, are available to those with behavioral health needs. There are many ways that a D-SNP can coordinate with carved-out systems even if they are not fully integrated.

### **3. ISSUES NOT RAISED IN THE REQUEST**

#### **Ombuds**

An external unbiased beneficiary support system, similar to the dual eligible demonstration ombuds, should be an essential component in designing a D-SNP framework. We know from discussions with advocates that many beneficiaries do not have a good idea of what they should be expecting from their D-SNP and, in fact, do not even know that they are in a D-SNP. Beneficiaries need unbiased assistance. Further, as has been seen in the demonstrations, an ombuds identifies systemic issues, significantly diminishes the need for appeals, and leads to better coordination among players. It is important that the ombuds be local to the state because the variations in Medicaid LTSS programs is so great. Relying on the Medicare ombuds, even if its scope were expanded, would not be sufficient.

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<sup>28</sup> See also, The SCAN Foundation, “The Coordination of Behavioral Health Care Through Cal MediConnect,” (Aug. 2017) available at [www.thescanfoundation.org/sites/default/files/coordination\\_of\\_behavioral\\_health\\_care\\_through\\_cal\\_medicconnect\\_brief\\_ucb-august\\_2017.pdf](http://www.thescanfoundation.org/sites/default/files/coordination_of_behavioral_health_care_through_cal_medicconnect_brief_ucb-august_2017.pdf).

## PlanFinder

Advocates and enrollment counselors have reported that they find it difficult to know which of the Medicare Advantage plans in their area are D-SNPs. For example, with a general search saying that the beneficiary receives Medicaid benefits, the results do not include any SNPs. It is necessary to choose the “Select Special Needs” option under “Refine my Search” and pick the sub-option “plans for people who are eligible for both Medicare and Medicaid” for D-SNPs to appear. Further, if a searcher chooses more than one SNP sub-option, it is not possible on the Plan Finder to determine which SNPs on the resulting list are D-SNPs and which are C-SNPs or I-SNPs.

A related issue is that, once a plan has been identified as a D-SNP, it is frequently difficult to determine the eligibility criteria, for example, whether only full benefit dual eligibles may join or if those only in Medicare Savings Programs are also eligible. We have looked at several plan websites, Summaries of Benefits, and even Evidence of Coverage documents and found it is often unclear even there. Instead plans urge readers to call the plan to get details.

These information gaps make it difficult for counselors to work effectively and efficiently to help beneficiaries understand the D-SNP option they may have.

## CONCLUSION

Though D-SNP enrollment already tops two million beneficiaries with over 400 plans,<sup>29</sup> the responses we receive from advocates in high concentration states suggest that many D-SNPs are doing little that distinguishes them from other Medicare Advantage products. We look forward to working with CMS to ensure that, going forward, the D-SNP standards do more to ensure that D-SNPs better serve the needs of their dual eligible members. We look forward to continuing to work with the agency in examining both the current realities and options for strengthening and improving delivery of integrated services through the D-SNP model.

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at [jgoldberg@justiceinaging.org](mailto:jgoldberg@justiceinaging.org).

Sincerely,



Jennifer Goldberg  
Directing Attorney

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<sup>29</sup> See Centers for Medicare & Medicaid Services, Special Needs Plan Comprehensive Report (Mar. 2018), available at [www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2018-03.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2018-03.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending).