DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE-MEDICAID COORDINATION OFFICE

DATE: March 13, 2018

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations, and Demonstrations

FROM: Tim Engelhardt, Director

SUBJECT: 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)

Section 50311(b) of the Bipartisan Budget Act of 2018 (Public Law No. 115-123)[1] creates a new Section 1859(f)(8) of the Social Security Act (the Act) in order to increase integration of Dual Eligible Special Needs Plans (D-SNPs). In particular, the statute directs CMS to: 1) develop unified grievance and appeals processes for D-SNPs; and 2) establish new standards for integration of Medicare and Medicaid benefits for D-SNPs. We are soliciting comments to help inform CMS' next steps related to unified D-SNP grievance and appeals processes and new integration standards.

1. Unified Grievance and Appeals Processes for Dual Eligible Special Needs Plans (D-SNPs)

The statute specifies a number of key elements for unified D-SNP grievance and appeals processes and grants the Secretary discretion to determine the extent to which unification of these processes is feasible. In particular, the unified processes must adopt the provisions from Section 1852(f) (Medicare Advantage grievances and appeals) and Sections 1902(a)(3) and (5), and 1932(b)(4) (Medicaid grievances and appeals, including managed care) of the Act that are most protective to the enrollee, take into account state Medicaid differences to the extent necessary, be easily navigable by an enrollee, include a single written notification of all applicable grievance and appeal rights, provide a single pathway at the plan level for resolution of a grievance and appeal, provide clear notices, employ unified timeframes for grievances and appeals, establish requirements for how the plan must process, track, and resolve grievances and appeals, and provide continuation of benefits pending appeal for services covered under Medicare Parts A and B, as well as Medicaid. The statute requires the Secretary to establish unified grievance and appeals procedures by April 1, 2020 and requires D-SNP contracts with state Medicaid agencies to use the unified procedures for 2021 and subsequent years.

We anticipate that unified grievance and appeals processes for D-SNPs would build on the experience we have gained working with Medicare-Medicaid Plans in the Financial Alignment Initiative. We welcome comments on all aspects of unifying the D-SNP grievance and appeals processes. We are particularly interested in comments on the following topics:

[1] Bipartisan Budget Act of 2018, H.R.1892, 115th Cong. (2018). Available at: https://www.congress.gov/bill/115th-congress/house-bill/1892/text.

- How to ensure that the unified grievances and appeals processes for D-SNPs limit administrative burden on plans and providers, and improve beneficiary experiences.
- Areas where current plan-level Medicare and Medicaid grievance and appeals processes differ and which processes are more protective of the enrollee. For example:
    - Medicare and Medicaid timelines for reimbursement appeals differ;
    - Filing of grievances is time-limited under Medicare but grievances may be filed at any time under Medicaid.
- Challenges to and potential options for applying unified Medicare-Medicaid grievance and appeals processes to D-SNPs that have different forms of Medicaid integration. For example, some D-SNPs coordinate with Medicaid but do not have contracts to provide Medicaid benefits. Other D-SNPs have members who have partial Medicaid benefits, who are in fee-for-service Medicaid, or who are in another organization's Medicaid product. Other D-SNPs are only permitted to enroll individuals who are also enrolled in a Medicaid managed care plan operated by the D-SNP's parent organization.
- Options for unifying and simplifying the appeals process beyond the plan level that preserve the beneficiary protections contained both in Medicare and Medicaid procedures.
- Any differences between Medicare and Medicaid, and suggestions for addressing them, particularly in the following circumstances:
    - Expedited appeals procedures;
    - What constitutes receipt of an appeal for purposes of starting the processing clock;
    - Circumstances under which the processing clock is suspended (tolling);
    - Gathering additional documentation from providers/prescribers during the appeal process.
- Suggestions for addressing differences between Medicare and state Medicaid procedures for appeals by in-network and out-of-network providers.
- Any state-specific legal provisions such as statutes, regulations, consent decrees, or other processes (such as the availability of state-level external review for Medicaid services) that could complicate unifying the grievance and appeals process at the plan level or beyond, and suggestions for addressing these concerns.
- Any operational or business needs of states, plans, providers, or other entities that necessitate categorizing grievances and appeals as either Medicare or Medicaid (e.g., state and federal reporting requirements, quality measures, or provider payment procedures).
- Challenges in and potential options for applying unified grievance and appeals processes to D-SNPs that operate under a contract that also includes other Medicare Advantage products (e.g., implications for reporting requirements).
- Considerations in applying benefits pending appeal to all benefits under Medicare Parts A and B, and Medicaid, such as applicability to supplemental benefits, and how to integrate benefits pending rules with existing Medicare fast-track appeal requirements for certain services.
- 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.
- 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.
- Use of other modalities to request an appeal such as orally and through an Internet website.

- Examples of well-crafted notices that could serve as models for creating new notices for the unified processes.

2. Requirements for Integration

The statute requires that, for 2021 and subsequent years, D-SNPs meet requirements for integration. Specifically, under the new Section 1859(f)(8)(D)(i) of the Act, D-SNPs "shall meet one or more of the following requirements, to the extent permitted under State law, for integration of benefits…" described below. The bill also gives the Secretary the authority to impose enrollment sanctions on plans failing to meet these integration standards in plan years 2021-2025.

1. Under subsection (D)(i)(I), a D-SNP must, in addition to meeting existing requirements of contracting with the state Medicaid agency under 1859(f)(3)(D), coordinate long-term services and supports (LTSS) and/or behavioral health services by meeting requirements for integration established by the Secretary based on input from stakeholders. Such requirements for integration could include:
   - Notifying the state in a timely manner of hospitalizations, emergency room visits, and hospital or nursing home discharges of enrollees;
   - Assigning one primary care provider for each enrollee; or
   - Sharing data that would benefit the coordination of items and services.

2. Under subsection (D)(i)(II), a D-SNP must meet FIDE SNP requirements at 1853(a)(1)(B)(iv)(II) (with the exception of the requirement that the plan have similar levels of frailty as the PACE program) or enter into a capitated contract with the state Medicaid agency to provide LTSS, behavioral health services, or both.

3. Under subsection (D)(i)(III), the parent organization of a D-SNP that is also the parent organization of a Medicaid managed care organization providing LTSS or behavioral services must assume "clinical and financial responsibility" for benefits provided to beneficiaries enrolled in both the D-SNP and Medicaid managed care organization.

We welcome comments on all aspects of D-SNP integration standards. We are particularly interested in comments on the following topics:

- Subsection (D)(i)(I) lists examples of potential requirements for integration. We welcome comments related to those examples.
- 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).
- 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.
- How CMS should consider partial carve-outs of Medicaid services in applying the criteria in subsection (D)(i)(II) and (III).
    - Should CMS consider a plan to be capitated for behavioral health services if certain behavioral health services remained carved-out and are provided by a state through fee-for-service? If so, how should CMS approach such analysis?
    - For LTSS services, should our assessment be any different than the current standard for FIDE SNP status? If so, how?

- Issues related to the timing, process, or criteria for FIDE SNP determination that CMS should consider in implementing the provisions of the Bipartisan Budget Act of 2018. (CMS currently determines FIDE SNP status on the basis of the state Medicaid agency contract submissions in early July.)
- Determining "clinical and financial responsibility," as described in subsection D(i)(III).
    - Should CMS 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)?
    - Are there any circumstances other than aligned D-SNP and Medicaid managed care enrollment under which an organization could demonstrate "clinical and financial responsibility" for benefits?

Please submit comments by April 12, 2018 with the subject line "Comments on Section 50311," to MMCOCapsmodel@cms.hhs.gov.