

December 31, 2018

Demetrios Kouzoukus  
Principal Deputy Administrator & Director of the Center for Medicare  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4185-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

Submitted electronically via email to <http://www.regulations.gov>

**Re: Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021**

Dear Principal Deputy Administrator Kouzoukus,

The Medicaid Health Plans of America (MHPA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid's (CMS) proposed rule on Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 released on November 1, 2018. MHPA's comments focus on the provisions of the proposed rule specific to new integration standards for dual eligible special needs plans (D-SNPs) and CMS' proposals to better unify the grievances and appeals processes across the Medicare and Medicaid programs in order to ensure access to seamless, coordinated care for dual eligible beneficiaries.

MHPA is the national trade association representing 93 private-sector health plans that contract with state Medicaid agencies in 39 states plus DC to provide comprehensive, high-quality health care to more than 25 million Medicaid enrollees in a coordinated and cost-effective way. According to a recent analysis by PWC, 73 percent of all Medicaid enrollees received their care through a private Medicaid health plan in 2017 (up from 66 percent in 2014) this number continues to rise annually as more states turn to the expertise of managed care plans to help coordinate health care for a growing number of Medicaid enrollees with diverse needs.

For the over 11 million dually eligible for Medicare and Medicaid, Medicaid plays a critical part in their full health coverage. Many MHPA plans serve dually eligible beneficiaries in some capacity and have long led efforts to improve care and coordinate benefits for this population. A number of MHPA's plans have diversified into the Medicare Advantage (MA) programs, particularly involved in serving dually eligible beneficiaries through special needs plans (D-SNPs). D-SNPs act in a broader, more comprehensive manner in serving this population and in coordinating benefits across Medicare and Medicaid programs.

Overall, MHPA appreciates CMS' continued commitment to increasing coordination across Medicare and Medicaid. Our member plans have extensive experience providing high quality,

comprehensive care to high-cost, high-need populations such as the dual eligible population, and we believe that we can be effective partners in helping to transform care for these beneficiaries.

### **General Comments on D-SNP Provisions**

In the proposed rule, CMS outlines proposals to implement provisions included under Section 50311(b) of the Balanced Budget Act of 2018 (BBA 2018) which established new requirements for D-SNPs to integrate Medicare and Medicaid benefits and imposed enrollment sanctions for plans that failed to comply with those requirements. The BBA 2018 also required the unification of Medicare and Medicaid grievance and appeals procedures to the extent feasible.

MHPA offers the following high-level comments on the key proposals included in the proposed rule specific to D-SNPs:

- I. Implementation of Statutory Requirements for D-SNP Integration:** Overall, MHPA supports the Agency’s proposals for the implementation of new requirements for D-SNP integration across Medicaid and Medicare programs and appreciates the flexibility afforded in the proposals to accommodate a variety of state and D-SNP contract arrangements.
- II. General Requirements for DSNPs Related to Medicaid Coverage Issues and Grievances and Appeals.** MHPA appreciates CMS’ efforts to improve coverage processes for this vulnerable population through better coordination and unification of grievances and appeals processes. However, MHPA but has some concerns that some of the new requirements may be overly burdensome to plans.
  - **Requirement for D-SNPs to Assist with Medicaid Coverage Issues and Grievances:** While MHPA supports the goal of assisting dually eligible beneficiaries with appeals and grievance processes, MHPA is concerned that CMS’ proposal that requires D-SNPs to be responsible for assisting with all Medicaid grievances and appeals processes—whether the Medicaid benefits are covered under the plan or in fee-for-service—may be overly broad and administratively complex for D-SNPs to accomplish effectively.
  - **Unified Grievance and Appeals for Applicable Integrated Plans:** MHPA appreciates and supports the Agency’s more incremental approach to creating a unified grievances and appeals process across Medicare and Medicaid focusing on implementing process for a limited subset of fully or highly integrated or exclusively aligned D-SNPs.

Below are our detailed comments on CMS’ proposed approaches for implementing these new requirements.

### **Detailed Comments**

#### **I. Implementation of Statutory Requirements for D-SNP Integration**

MHPA appreciates CMS’ efforts to implement the new requirements for D-SNP integration in a manner that maintains flexibility for states in D-SNP contracting, builds on existing state and D-SNP process infrastructure and does not unduly increase administrative burdens for states and plans. Our comments on specific proposed changes follow:

**CMS' Proposal on D-SNP Definition (§422.2).** CMS proposes to add or revise certain definitions relating to D-SNPs to clearly establish requirements for these plans and to specify different types of D-SNPs based on the degree to which they integrate benefits at the plan level. CMS proposes to include new or revised definitions for D-SNPs, highly integrated D-SNPs (HIDE-SNPs), fully integrated D-SNPs (FIDE-SNPs), “aligned enrollment” and “exclusively aligned enrollment”.

Specifically, CMS proposes to revise the definition of a D-SNP to align with the statutory requirements beginning in 2021 and to establish that for “a plan that is neither a HIDE SNP nor FIDE SNP, the plan will notify the state Medicaid agency of hospital and skilled nursing facility (SNF) admissions for at least one group of high-risk full-benefit dual eligibles.”

- **MHPA supports this proposed definition for D-SNPs.** MHPA also appreciates that CMS has maintained flexibility for existing D-SNP arrangements to have a path toward meeting the new integration standards.

**CMS' Proposals for Related Definitions Including for HIDE-SNPs and Aligned Enrollment (§422.2).** In addition to revisions to the definition for FIDE-SNP which include adding behavioral health to the list of services that can be covered under the contract as well as requiring FIDE-SNP contracts to include nursing facility coverage for at least 180 days a plan year, CMS proposes to include a definition for HIDE-SNP which had previously not been codified. HIDE-SNPs would be defined as meeting the definition for a D-SNP but whose parent organization—or other entity owned or controlled by the parent organization—has a capitated contract with the state that covers LTSS, behavioral health services, or both, consistent with state policy. The definition covers arrangements that are “consistent with state policy” in order to accommodate the variety of state coverage engagements for LTSS and behavioral health services.

CMS also proposes to newly define “aligned enrollment.” Aligned enrollment would be when a full benefit dual eligible enrollee in a D-SNP has Medicaid benefits covered by the D-SNP or by a Medicaid managed care organization (MCO) that (i) has the same organization as the Medicare Advantage organization offering the D-SNP, (ii) is its parent organization, or (iii) is another entity owned/controlled by the parent organization.

Further, CMS defines “exclusively aligned enrollment” as when a state Medicaid policy limits D-SNP membership to individuals with aligned enrollment.

- **MHPA supports CMS' proposed changes and additions to definitions to implement the statutory requirements for integration and aligned enrollment.** MHPA believes that these the new definitions—and clarifications—in terminology related to D-SNPs will further the goal of driving both integration and innovation in care delivery and coordination. Specifically, MHPA believes the definitions provide greater clarity on the types of integrated arrangements that may be available to states. MHPA also appreciates the clarification on HIDE-SNPs and how those differ from FIDE-SNP arrangements but still meet the requirements under the BBA 2018.

**CMS' Proposal on D-SNP Minimum Contracting Requirements with States—Notification of Beneficiary Admission to SNF or Hospital for At Least One Group of High-Risk, Full-Benefit Dual Eligible Beneficiaries (§422.107(d)).** As part of minimum contracting requirements for

certain D-SNPs (those that are not HIDE-SNPs or FIDE-SNPs), CMS proposes that the plan must notify the state Medicaid agency of hospital and skilled nursing facility (SNF) admissions for at least one group of high-risk, full-benefit dual eligibles, as determined by the state Medicaid agency (i.e. states would identify the subpopulations of dual eligibles required for this notification). The proposal is intended to allow states flexibility in determining the high-risk populations on which the state will focus and to allow the state to test different approaches for improving care coordination, as well as permitting states to set the notice parameters and procedures related to the notification requirements for these beneficiaries.

- **MHPA supports this proposal and agrees that it promotes the ability of states to develop greater care coordination programs for beneficiaries, particularly around care transitions.** MHPA also believes that the proposal permits states and plans to build on processes already in place or available to the state for notification of these vulnerable population groups.

**Eligibility of Partial-Benefit Dual Eligible Individuals for D-SNPs.** CMS is considering limiting enrollment in D-SNPs for full-benefit duals and is requesting comments on this proposal.

- **MHPA does not support establishing limits on the enrollment of partial-benefit dual eligible individuals in D-SNPs and encourages CMS not to move forward with this proposal.** MHPA does not support this proposal because there is a fair amount of churn between the different dual eligible eligibility categories and plans support the continued availability of care and coordination of care across the entire dual eligible population.

## **II. Requirements for D-SNPs to Assist with Medicaid Coverage Issues and Grievances, and Develop Unified Grievance and Appeals for Applicable Integrated Plans**

The BBA 2018 requires the Agency to establish a unified grievances and appeals process which brings together, to the extent feasible, procedures unifying grievances and appeals procedures for Medicare and Medicaid items and services provided by D-SNPs. To meet the provisions of the BBA 2018, CMS developed the following goals: (i) adopt provisions most protective of enrollees; (ii) reduce burden on beneficiaries, plans, states, and providers; and (iii) maintain state flexibility and minimize disruption by building on existing policies.

- **MHPA agrees with these overall goals and offers comments on the specific policy modifications CMS is proposing.**

### **General Requirement for D-SNPs to Assist with Medicaid Coverage Issues and Grievances**

**(§422.562(a)(5)).** CMS would require all D-SNPs to assist their full-benefit, dual eligible enrollees with Medicaid-related coverage issues and grievances. Generally, CMS believes D-SNPs should help enrollees file grievances, request coverage, and request appeals to resolve Medicaid coverage issues—whether the coverage is provided under Medicaid fee-for-service or an MCO. CMS also proposes to require D-SNPs to provide this assistance “whenever it becomes aware of an enrollee’s need” for help for a Medicaid-covered service and proposes to have D-SNPs provide CMS documentation of the plan assistance to enrollees upon request.

Although MHPA supports the goals of these proposals, we are concerned about the extent of the requirements on plans and the administrative complexity that may be needed to comply. First, we are concerned that the requirement to assist with appeals and grievances outside of the plan's contracted coverage requirements may require plans to assist in an area for which they do not currently have expertise. As a result, plans may need to hire additional staff or dedicate additional resources to cover this requirement, despite the fact that many D-SNPs currently assist enrollees with needed materials and provide support for Medicaid appeals.

Further, the requirement that plans provide this assistance whenever they are made aware of these issues, as opposed to upon request from enrollees, creates an affirmative requirement on plans that may not be in a position to assist enrollees. This could also create complexity for enrollees who may be addressing the issue on the Medicaid side without the assistance of plans. Additionally, we are concerned that requiring documentation of assistance will also increase burden on plans.

- **MHPA has concerns with CMS' proposal to add new requirements for all D-SNPs to help enrollees with Medicaid coverage issues and grievances, no matter the Medicaid coverage provided is through a health plan or through Medicaid fee-for-service.** MHPA encourages CMS to modify these proposals so that the situations when D-SNPs should assist with the coverage and grievance are well-defined and clearly within the purview of the plan.

**Unified Grievance and Appeals for Applicable Integrated Plans** For a limited set of D-SNPs (FIDE-SNPs, HIDE-SNPs, and D-SNPs with exclusively aligned enrollment) CMS would create an integrated grievance and appeals system. CMS proposes to establish a federal floor framework but will permit states to implement standards that are more protective for enrollees, for example, with respect to timeframes or notice

- **MHPA appreciates the complexity of developing a unified grievance and appeals process for D-SNPs. We support CMS' proposal to limit the development of this process to a subset of D-SNP plans (e.g. FIDE SNPs and HIDE SNPs) that have exclusively aligned enrollment and the affiliated Medicaid MCO through which enrollees receive Medicaid services.** While we recognize this is limited to a subset of D-SNPs, we believe it is important to assure that the proposed unification is feasible. To this end, we support aligning the process as closely as possible with the unified processes implemented under the Financial Alignment Demonstration.

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Thank you for the opportunity to provide input on the D-SNP provisions included in this proposed rule. We look forward to working with you to help implement these changes and welcome the opportunity for continued dialogue and collaboration with you in addressing the needs of dual eligible beneficiaries.

Sincerely,

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