



April 12, 2018

Tim Engelhardt
Director
Medicare-Medicaid Coordination Office
7500 Security Boulevard
Baltimore, MD 21244

Dear Director Engelhardt,

On behalf of the nation's Medicaid Directors, we appreciate the opportunity to provide written comments informing the Medicare-Medicaid Coordination Office's planned rulemaking implementing integration standards and a unified grievances and appeals process for Duals Special Needs Plans (D-SNPs), as required by the Bipartisan Budget Act of 2018.

The National Association of Medicaid Directors (NAMD) is a bipartisan, nonprofit, professional organization representing leaders of state Medicaid agencies across the country. Our members drive major innovations in health care while overseeing Medicaid, which provides a vital health care safety net for more than 72 million Americans. In FY 2013, nearly 11 million of these beneficiaries were dually eligible for Medicare and Medicaid.¹

Medicaid Directors view these regulations as an opportunity for the federal government to support ongoing state efforts to advance care integration for duals. In general, federal parameters in both the integration standards and in unified grievances and appeals processes should provide a national framework for integration which both meets states where they are in this work and provides a clear path forward for states and plans. The goal of this work should be to create an environment which encourages and supports continual integration, with elevated expectations for plans demonstrating the capacity to provide this integration. This steady advancement of integration and performance aligns with strategies states are currently employing in existing duals-oriented programs.

¹ Medicaid and CHIP Payment and Access Commission. "MACStats: Medicaid and CHIP Data Book." Exhibit 14a, p. 39. <https://www.macpac.gov/publication/medicaid-enrollment-by-state-eligibility-group-and-dually-eligible-status/>

Requirements for Integration

Section 50311(b) of the Bipartisan Budget Act of 2018 sets statutory parameters for D-SNP integration. D-SNPs must meet one of the three parameters, to the fullest extent allowed under state law, by program year 2021. These parameters fall into three broad categories:

1. Meets CMS-developed integration requirements.
2. The D-SNP is a FIDE SNP.
3. The D-SNP parent organization is also the parent organization of a Medicaid managed care plan and assumes clinical and financial responsibility for beneficiaries enrolled in both the D-SNP and the Medicaid managed care plan.

We focus our comments on the first parameter, as we believe parameters two and three are straightforward. The parameters CMS sets for integration will have considerable impact on the treatment of the unified grievances and appeals process, thus we address this aspect first.

CMS's integration requirements represent an opportunity to incentivize currently non-integrated D-SNPs to become more integrated. A clear signal from our federal partners will empower states in achieving integration goals. Conversely, should CMS set limited, easily achievable integration requirements, then current non-integrated D-SNPs may not feel the same need to enhance their offerings. This would be a missed opportunity.

One approach would be for CMS to analyze current state Medicare Improvements for Patients and Providers Act (MIPPA) agreements, identify common MIPPA elements or standards in high-performing integration programs, and set these standards as the floor for federal expectations going forward – with the important stipulation that states retain the ability to leverage MIPPA agreements to set higher integration standards than the federal minimum. While such an approach may be challenging for current non-integrated D-SNPs to meet, an ambitious federal standard would allow states to maximize the potential for integration that the D-SNP model represents. Alternatively, CMS may consider gradually elevating D-SNP integration standards over a specified time period to provide a smoother transition towards heightened integration expectations.

As part of its integration standards, CMS should establish a menu of data sharing requirements for D-SNPs from which states may select for inclusion in their MIPPA agreements going forward. While we recognize that states can currently leverage these agreements to identify their own data sharing requirements, a federal menu of options and an expectation of data sharing between D-SNPs and the states promotes consistency and gives states stronger tools for engaging with their D-SNP partners. Potential data elements to share could include hospital



and nursing facility admission and discharge information, supplemental benefit bid information, risk scores, claims and encounter data, and quality and compliance data.

States should have a well-defined role in assessing plan compliance with the federally-developed integration standards, particularly for any higher standards that may be imposed by the state. Additionally, states should have the option to be the primary assessor of compliance with integration standards, with the option to defer assessment to CMS.

Unified Grievances and Appeals

Effective addressing of beneficiary grievances and an effective, integrated appeals process will require federal flexibility for states to employ multiple models. Current D-SNP programs and models from the Financial Alignment Initiative (FAI) demonstrations provide useful starting points for the types of models that should continue to be supported going forward.

For example, the Minnesota model prioritizes a seamless, beneficiary-oriented process that uses integrated eligibility determinations and plan notices to minimize confusion for beneficiaries. This model provides individuals with the information necessary to make informed decisions and exercise their rights under each program. Should an appeal be necessary, the Medicaid and Medicare appeals processes run in parallel, but do not require the beneficiary to navigate separate processes. The result is that back-end coordination between Medicare and Medicaid produces an integrated beneficiary experience.

Another model could be derived from the New York FAI demonstration, in which the state created an integrated appeals office to manage both Medicaid and Medicare appeals. However, should this model be scaled up across the nation, states may need additional resources to create and sustain integrated appeals offices. This support could be an enhanced federal match to reflect the state's adoption of the Medicare appeals function.

States do not support CMS creating a federal entity to manage Medicaid appeals. Many states see Medicaid D-SNP appeals occurring primarily in personal care services and other highly localized services. These are most appropriately handled at the state level.

We thank you for your consideration of state perspectives on these issues, and look forward to the opportunity to provide additional comments as rulemaking progresses.



Sincerely,

A handwritten signature in blue ink that reads "Judy Mohr Peterson".

Judy Mohr Peterson
Med-QUEST Division Administrator
State of Hawaii
President, NAMD

A handwritten signature in black ink that reads "Kate McEvoy".

Kate McEvoy
State Medicaid Director
State of Connecticut
Vice President, NAMD