



Getting Medicare right

April 12, 2018

**VIA ELECTRONIC SUBMISSION**

**RE: 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)**

The Medicare Rights Center (Medicare Rights) is pleased to submit comments in response to the Request for Stakeholder Input regarding implementing the D-SNP provisions of the Bipartisan Budget Act of 2018 (BBA). Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

The following comments are informed by our experience assisting beneficiaries, their family members, and health care professionals, particularly in their experience with the New York State Medicare-Medicaid Fully Integrated Duals Advantage (FIDA) Plans, D-SNPs, and other programs that serve dually eligible New Yorkers. For additional information, please contact Lindsey Copeland, Federal Policy Director at [LCopeland@medicarerights.org](mailto:LCopeland@medicarerights.org) or 202-637-0961 or Casey Schwarz, Senior Counsel, Education & Federal Policy at [CSchwarz@medicarerights.org](mailto:CSchwarz@medicarerights.org) or 212-204-6271.

Individuals who are dually eligible for Medicare and Medicaid (“dual eligibles”) are poorer and sicker than the rest of the Medicare population.<sup>1</sup> Eighteen percent of dual eligibles report being in poor health, compared with six percent of non-dual Medicare beneficiaries.<sup>2</sup> They are also more likely to be institutionalized than non-dual eligibles (21 percent vs. 5 percent), and account for a disproportionate share of both Medicare and Medicaid spending.<sup>3</sup> Dual eligibles are more likely than other Medicare beneficiaries to have three or more chronic conditions or be diagnosed with mental illness and are likely have more need for assistance in performing activities of daily living (ADLs), such as bathing, toileting and getting dressed.<sup>4</sup>

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<sup>1</sup> MedPAC & MACPAC, “Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid,” Ex.4, 7 (January 2018), [http://medpac.gov/docs/default-source/data-book/jan18\\_medpac\\_macpac\\_dualsdatabook\\_sec.pdf?sfvrsn=0](http://medpac.gov/docs/default-source/data-book/jan18_medpac_macpac_dualsdatabook_sec.pdf?sfvrsn=0).

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

<sup>4</sup> MedPAC, “Report to Congress: Medicare and the Health Care Delivery System, Chapter 9 Issues affecting dual eligible beneficiaries: CMS’s financial alignment demonstration and the Medicare Savings Programs” (June 2016), <http://www.medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf?sfvrsn=0>.

According to the New York State Department of Health (NYSDOH), as of February 2018 almost a third of the over 700,000 full dual eligible New Yorkers are enrolled in some type of managed care product.<sup>5</sup> However, with the exception of those enrolled in Programs of All-Inclusive Care for the Elderly (PACE) or FIDA, these plans do not fully coordinate and integrate Medicare and Medicaid services. Our helpline and casework experience shows that beneficiaries experience fragmented care and often find the assistance offered by plans in navigating their care lacking. Many dual eligible New Yorkers face significant challenges accessing needed care which may result in otherwise avoidable hospitalizations, duplication of services, and poorer health outcomes.

Some dual eligible New Yorkers may have to navigate multiple sources of health coverage to access necessary care and services. This can be burdensome and inefficient, and even where a person has a potentially unified plan like a D-SNP or a FIDA plan, points of dis-integration can cause significant confusion, challenge and harm. For example:

- Coverage rules and procedures differ under each program;
- Written information comes from multiple sources with no single comprehensive description of the sum total of benefits, procedures, or rights and responsibilities applicable to dual eligibles;
- Processes for grievances and appeals may differ, as to notices relating to both coverage determinations and grievances and appeals;
- Responsibility for delivering necessary services is divided between different programs, making it hard to know where to go when problems present;
- Providers are challenged to understand how the different types of coverage interact and how to proceed when they conflict; and
- Providers across programs have little or no established mechanisms through which to communicate.

In our experience, many dual eligible New Yorkers have cobbled together what they perceive to be integrated high quality care. Both individuals enrolled in fee-for-service Medicare and those in a Medicare Advantage product work with their primary care providers to achieve a minimum level of coordination. Yet, many people struggle with navigating their multiple plans or sources of coverage and face challenges in trying to access all of their needed care. Often, it is when there is a problem in access or payment that the fractured nature of their coverage becomes apparent. Therefore, integration of the appeals and grievance systems—where patients and providers turn when there is an issue—is of utmost importance.

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

Understanding which aspects of a person’s health care are covered under different programs, and therefore to which entity to appeal a denial or file a grievance are some of the most complicated questions for beneficiaries, advocates, and even providers. Even the seemingly simple fact that prescription drugs are covered by Part D has a litany of asterisks and exception. For example, some drugs, like those provided and administered by a physician, are covered under Part B, unless they are picked up at the pharmacy and brought to the doctor’s office (Part D) or supplied as part of a covered inpatient stay at a Skilled Nursing Facility or Hospital (Part A) or are prescription vitamins (usually Medicaid). Other

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<sup>5</sup> New York Dept. of Health, “Medicaid Managed Care Enrollment Reports,” [https://www.health.ny.gov/health\\_care/managed\\_care/reports/enrollment/monthly/](https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/) (this does not include dual eligibles enrolled in Dual Special Needs Plans).

services may be even more challenging to tease out, especially as Medicare Advantage plans, including D-SNPs, expand the supplemental benefits under recent authority.<sup>6</sup>

Indeed, the better a plan executes their primary objective of integrating the services under Medicare and Medicaid, the more challenging it becomes to identify which services are “under” each program and what rights attach. Therefore, a truly integrated grievance and appeals process is essential.

A unified process must not only limit administrative burden on plans and providers. It must also limit the “administrative” burden of directing and organizing the appeal that largely falls on beneficiary shoulders, and it must retain the more protective of the applicable rules, including timely access to an impartial adjudicator. This unified process must take into account the ways in which different appeals rules currently exist *within* Medicare, in addition to the differences between Medicare and Medicaid.

Plans that are directly marketed toward and aim to serve the duals population must not be permitted to do so in ways that add to the challenges faced by beneficiaries seeking to avail themselves of the full complement of benefits to which they are entitled. If a D-SNP does not have a contract to provide Medicaid benefits or is otherwise not empowered to act on an appeal or grievance related to a Medicaid benefit, their case management obligations should include assisting and re-directing any appeal or grievance received. That is, even if the appeals and grievance processes cannot be fully integrated, there must be no-wrong-door to access any of those processes. Providing aid-to-continue or aid paid pending review for all claims—both Medicare and Medicaid—must be part of this unification.

Unification and simplification at the post-plan appeals levels will require significant training and support for adjudicators to learn about and evaluate claims based on potentially unfamiliar processes and laws. Those situations where the same item or services may be covered under Medicare and Medicaid but for which different clinical or coverage standards apply are some of the more challenging cases for beneficiaries and advocates to resolve. These frustrating cases often require significant, time-intensive coordination between different responsible parties.

While a fully integrated benefit and appeals process, where the differences between Medicare and Medicaid (and Part D) services are irrelevant to beneficiary decision making, is a laudable goal, we are not yet there. Instead, notification to beneficiaries when, for example, Medicare denies a claim that is paid by Medicaid remains crucial for a few reasons. First, it remains important for enrollees to understand and appreciate that their continued receipt of certain services depends on their continued enrollment in Medicaid. Second, integration should not mean shifting costs from Medicare to Medicaid, or vice versa. Requiring documentation and notice when the primary payer refuses coverage could help identify improper patterns if, for example, Medicare claims for a particular service are improperly denied to dual eligibles.

## **2. Requirements for Integration**

The BBA requires that, for 2021 and subsequent years, D-SNPs meet new 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

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<sup>6</sup> The Bipartisan Budget Act of 2018 (Public Law No. 115-123) Section 50322; Currently Unpublished Final Rule <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-02.html#>.

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.

- a. 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.
- b. 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.
- c. 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 suggest assigning a care manager/point person at the D-SNP who can assist with coordinating care by locating in-network providers, assisting with appeals, troubleshooting, and smoothing interactions between programs, rather than assigning a provider to serve in this role. This care manager should be responsible for assisting the beneficiary in accessing all necessary services, including carved out services and services for which other payers are responsible. The care manager should be empowered (with beneficiary consent) to coordinate and plan between providers and payers to effectuate seamless access to needed services. To the extent that a provider serves as a central point for case management and decision-making, these providers should not be assigned but chosen by beneficiaries. The beneficiary should also be permitted to elect a specialist if that provider would be better suited to operate as the central point based on the unique medical situation of the patient.

We strongly urge CMS to require robust and meaningful care management, which we do not frequently see in existing D-SNPs. Mere notification to the state of hospital and nursing home discharge is insufficient to effectively integrate LTSS. Instead, CMS should look to models like Interdisciplinary Teams for integrated, comprehensive, person-centered decision making.

Data sharing is an essential component of any integrated plan. Medicare and Medicaid claim information must be accessible to the plan, the care manager, and the beneficiary. To the extent agreed to by the beneficiary, all providers should have seamless access to these records to know whether certain tests or procedures have been performed and what the results were. In New York, providers reported that they

faced challenges accessing patient records from health plans in the FIDA program<sup>7</sup> and that lacking access to data and information was an obstacle to participating in FIDA Interdisciplinary Team meetings and in prescribing certain services.<sup>8</sup>

CMS should also consider requiring coordinated access to all services including durable medical equipment (DME), supplies, and drugs (prescription and over-the-counter); requiring the creation of a care plan for all enrollees; and requiring the creation of standardized notices, including Evidence of Coverage (EOC) and Annual Notice of Change (ANOC) documents that outline both Medicare and Medicaid benefits.

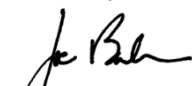
In our experience, New York D-SNP enrollees do not experience integration of their Medicare and Medicaid services. For example, it is common that when an enrollee has a Medicaid issue the D-SNP directs the enrollee to the local district office. We hear from D-SNP enrollees who have issues, such as their provider not receiving a secondary payment from Medicaid, yet the D-SNP has no mechanism to assist, no knowledge of or familiarity with local Medicaid procedures and rules, and no connections or contacts at those offices. This is inadequate, and places the burden of coordinating between bureaucracies back on the individual enrollee.

There should be oversight by both CMS and the state. In New York's FIDA program, it is helpful that both CMS and NYSDOH are at the table to ensure that plans are complying with contract requirements. In New York's Managed Long-Term Care program, care coordination is required but there seems to be little oversight to ensure that this care coordination is occurring. We have heard from partner organizations in New Jersey that D-SNPs are successfully coordinating care because the state is in constant communication with the plans to make sure they are in compliance. We do not see this happening in New York and therefore including CMS might motivate the state to make sure that contract terms are being met.

This oversight should be transparent and accessible to beneficiaries, advocates, and researchers. Enrollee complaints of significant severity or magnitude should trigger investigation and reports from both routine and incident related audits and oversight should be made public.

Thank you for the opportunity to provide comment. We look forward to the development of more robust rules and structures to ensure that D-SNPs fully serve this vulnerable population.

Sincerely,



Joe Baker  
President

Medicare Rights Center

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<sup>7</sup> RTI International, "Early Findings on Care Coordination in Capitated Medicare-Medicaid Plans under the Financial Alignment Initiative," p. 24 (March 2017), <https://innovation.cms.gov/Files/reports/fai-carecoordination-issuebrief.pdf>.

<sup>8</sup> *Id.*