



April 12, 2018

Emailed to: MMCOCapsmodel@cms.hhs.gov

Mr. Tim Engelhardt
Director
Medicare-Medicaid Coordination Office
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Comments on Section 50311

Dear Mr. Engelhardt:

LeadingAge appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) plans for implementing the dual eligible special needs plans (D-SNPs) provisions of the Bipartisan Budget Act of 2018 (Public Law No. 115- 123). We would like to note that LeadingAge has identified integrated services as a top policy focus. Our vision for integrated services is outlined in our white paper entitled, "Integrated Service Delivery: A LeadingAge Vision for America's Aging Population." Our comments will stem from the essential elements of integration we discuss in that document (<http://leadingage.org/integrated-service-delivery-report>).

The members of LeadingAge and affiliates touch the lives of 4 million individuals, families, employees and volunteers every day. The LeadingAge community (www.LeadngAge.org) includes 6,000 not-for-profit organizations in the United States, 38 state partners, hundreds of businesses, research partners, consumer organizations, foundations and a broad global network of aging services organizations that reach over 30 countries. The work of LeadingAge is focused on advocacy, education, and applied research. We promote home health, hospice, community-based services, adult day service, PACE, senior housing, assisted living residences, continuing care communities, nursing homes as well as technology solutions and person-centered practices that support the overall health and wellbeing of seniors, children, and those with special needs.

Below are our thoughts and feedback on the two areas that you requested comments on:

(1) Considerations of best approaches to a unified grievance and appeals for D-SNPs; and (2) Requirements for Integration for D-SNPs.

Considerations of best approaches to a unified grievance and appeals for D-SNPs

While we do not purport to be experts on all of the requirements plans must abide by related to grievances and appeals, we would offer the following key principles for your consideration:

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- There should be a no wrong door approach that allows enrollees, relatives, and providers to submit grievances and appeals to a single-entry point and on a unified form to the plan for consideration.
- Plans should be required to report their number of grievances and appeals, time it took to address the grievance or appeal and close the item and types (e.g. provider payment of claims, medical review, customer service, co-pays being charged to duals, etc.) so patterns can be identified and corrections made, where appropriate.

In addition, the memorandum asked to what extent enrollees should be required to provide written consent when someone other than the enrollee (like a provider, relative, etc.) is requesting an appeal. We would suggest that enrollees not be required to provide written consent when a provider is appealing a denial of a claim for a service provided to the enrollee by the provider. This would place undue burden on the enrollee and likely have the effect of limiting providers' ability to obtain reimbursement owed them for services rendered. However, enrollees should be informed if an appeal request has the possibility of negatively impacting them.

With regard to the use of other modalities to request an appeal such as orally and through an Internet website, again, we believe there should be no wrong door approach for enrollees, relative or providers to submit a grievance or appeal to a plan. Each plan should assign a ticket number to each grievance or appeal so that the submitter can track it. Given the distances that can exist sometimes between enrollees and their family members, it would be desirable for all submitters to have the option to submit grievances and appeals through multiple sources (e.g., phone, website or paper).

Requirements for Integration for D-SNPs

In general, LeadingAge supports efforts to require true integration for dual eligibles and other older adults, such as adding the requirement that D-SNPs demonstrate integration by coordinating long-term services and supports (LTSS) and behavioral health services for their enrollees.

We believe integration must include the following expectations whether delivered by a group of accountable providers or a health plan. Below we have outlined a few key elements we feel are essential to achieving integration and the suggested role D-SNPs could/should play in meeting those objectives.

Required Integration Element	Role of the D-SNP
Pooled funding to address enrollees' needs	State and federal requirements achieve this objective through the existing structure of FIDE SNPs and those D-SNPs whose parent organization also has Medicaid managed care plan. However, we recognize that for Medicare plans that have to coordinate with a separate Medicaid plan, there are challenges to resolve. It is not clear how the appropriate financial alignment and integration can successfully be achieved. One possible way

	<p>might be for state and federal governments to identify performance measures for these plans that require the two plans to communicate and coordinate. For example, one approach might be for CMS to require D-SNPs and Medicaid plans to jointly develop a single care or service plan with the enrollee within XX days of enrollment; and coordinate regular reviews and updates every X months. Or perhaps incenting these D-SNP and Medicaid plans to notify each other of key care transitions in advance of transition. By adopting these two approaches, perhaps the right care or services could be identified more quickly to avoid unnecessary higher cost options and achieve more optimal outcomes for the enrollee.</p>
<p>All service providers must communicate, coordinate and collaborate around identifying and addressing the needs of the enrollee/individual</p>	<p>Align payment incentives and performance measures to incent providers to work toward a common goal including encouraging communication, rewarding providers for collaboration and avoidance of unnecessary, high cost service utilization. Providers should share in the financial incentives that plans receive for good performance and positive enrollee outcomes.</p>
<p>Conduct comprehensive assessments that support developing an all-inclusive individualized service plan.</p>	<ul style="list-style-type: none"> • Conduct assessments that look at all aspects of the enrollees’ needs (including those not exclusively the domain of the health plan): health care conditions and diagnoses; all current service providers; cognitive and functional capabilities, social determinants of health (e.g., stable, affordable housing, nutrition security, and transportation), their living environment (e.g., safety considerations/risks of falls) and other supports (e.g. family caregivers). • Use this information to develop a single plan for the best ways to address the older adult’s needs. The plan will evolve as changes present themselves and will be updated with input from contributing service providers, the enrollee and their family. • Use technology to share information among providers, payers and the individual and their family caregivers efficiently and timely. • Establish a process for how the service plan is revised based upon this input.
<p>Provide a single service facilitator that serves a multi-functional role</p>	<p>Often today, older adults are assigned a care coordinator or manager by the plan, a discharging hospital social worker, a nursing home discharge planner, and maybe another care</p>

	<p>coordinator in their primary or specialty clinic. Each coordinator has a scope of responsibility that ends at when the enrollee leaves their site of service and doesn't result in ongoing involvement or comprehensive knowledge of the enrollee. Regrettably, the result of this fragmented approach is individuals receive inappropriate care, inconsistent care instructions and can lead to undesirable and unnecessary outcomes. Integration means that services are brought to bear that reflect an understanding of more than the symptoms but the whole person.</p> <p>Plans should identify for every enrollee a single person they can contact to:</p> <ul style="list-style-type: none">• Identify and explain available care and service options to address their needs.• Assist with self-management information to help the enrollee manage their own conditions.• Obtain answers, clear up confusion and ensure optimal outcomes by getting answers from the individual's provider team.• Help the individual navigate the health care and support systems to ensure needs are met in a timely manner (e.g., securing necessary follow up appointments, assisting with care transitions). <p>This person can be someone at the plan but the plan should also be able to delegate these responsibilities to a provider or an appropriate housing or services organization for a fee. Ultimately, this go-to person for the enrollee is there to build bridges where there are gaps.</p>
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Additional considerations for expectations of D-SNPs:

- In your March 13, 2018 memorandum requesting stakeholder input, one of the suggested requirements for D-SNPs to demonstrate integration is to notify the state of hospitalizations, ER visits or hospital or nursing home discharges. This requirement is confusing to us. First, it is not clear what action the state would be expected to take with this information given that the D-SNP is responsible for either providing or arranging for Medicaid benefits for its enrollees. In addition, it is not clear how the enrollee's outcomes would be improved by the state having this information. Finally, unless the plan is actively engaged in care management with an assigned service facilitator or other care manager who has established communication expectations with an enrollee's service providers, the plan would not know of these events until after a claim was submitted unless a prior authorization was required for the admission or discharge. Therefore, the information would not

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be timely for the purpose of any kind of care coordination or intervention. Perhaps we misunderstood the intent, for we do think there can be great benefit to D-SNPs, as well as other managed care plans, being required to share claims and clinical outcome data with providers as well as state and federal government. Access to this type of data can help in identifying best practices, service delivery pattern trends and changes, as well as areas of unmet needs for the beneficiary. This data can also assist states in their important contract management roles by: 1) identifying service delivery trends and corresponding outcomes; 2) evaluating the adequacy of provider rates and any resulting gaps in access to certain types of providers; and 3) ensuring plan accountability for the contract terms, expected outcomes and delivering value.

- We would also ask CMS and state Medicaid contracts to require standardized billing forms and establish some protections for providers related to prior authorizations, medical reviews (e.g., limit the percent of cases to be reviewed if provider has been compliant historically), fee-for-service as a rate floor to preserve access, and value-based payment arrangements for providers who achieve certain performance outcomes. Providers are experiencing administrative burden of keeping track of multiple plans' requirements for billing, prior authorizations, medical reviews, clawback and restoration of payments, which detracts from their primary function of providing care and services that help enrollees maintain or regain their health and independence. This should be true for all Medicare Advantage and Medicaid managed care plans not just D-SNPs.

Thank you again for your consideration of our suggestions on how D-SNPs can demonstrate integration for their enrollees while preserving important protections for their enrollees, the providers who serve them and the states who seek to coordinate benefits with them. We would be happy to discuss our thoughts further.

Sincerely,



Nicole O. Fallon
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