New Medicare-Medicaid Integration Policies in the CY 2020 C&D Final Rule
D-SNP Medicare-Medicaid Integration Requirements
Vanessa Duran, FCHCO
Marna Metacalf Akbar, FCHCO
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D-SNP Unified Appeals and Grievance Processes
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Kaye Rabel: Our next session features a panel of speakers who will provide participants with an understanding of new rules related to Dual Eligible special needs plans codified in Parts C and D rule. The session will also highlight the policy and legal contexts for making these updates to the regulations. The specific regulation changes in operational consideration as CMS and states move forward with implementing the Final Rule.

The Final Rule was still being updated as we were planning for this event, and as a result, we are extending this session for an additional 15 minutes for the presenters to share some additional information related to those updates.

So, from the Medicare-Medicaid Coordination Office, please help me welcome Vanessa Duran, Marna Metcalf-Akbar, Paul Precht, Marc Steinberg, and Tobey Oliver.

[applause]

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Okay, we'll get started in just a minute. I don't think my clicker is working.

Next slide, please.

Vanessa Duran: Good afternoon. My name is Vanessa Duran. I am here with a really fantastic group of folks from the Medicare-Medicaid Coordination Office. We're going to be talking a little bit to you about the work that we've been doing since February of 2018 to implement the D-SNP-related provisions of the Bipartisan Budget Act of 2018.

There is a lot going on in the Dual Eligible space right now, so we will be focusing particularly on the Part C and D rule that was published in April of – April 16 of last month. But you guys have already gotten started on this on the polling question. So many of you were sleepy, I wanted to make sure that you were bright eyed and bushy tailed and that we – we knew what you – we were – who we were talking to, so we were wondering how many of you were representing s, non-MA plan D-SNPs, PDP, or another organization.

So, it sounds like we have a fairly mixed crew here. Obviously, all are welcome, and we're really excited to share these updates with you.

Okay. Next slide, please.

So there's a –

Excuse me.

Yes. There's a lot in the Final Rule. We're going to get to that first slide in a minute. Perfect.

We're going to just start off –

(Inaudible.)

Ah, thank you.

We're going to start off with a summary of the Medicare-Medicaid integration requires in the BBA, and sort of walk you through a little bit about what we've done with new and revised definitions in the Rule, as well as updates to MIPPA contracting requirements. And a new provision that we've established to require D-SNPs to provide assistance to their members on Medicaid coverage issues. We're then – and Marna is going to help me out with that.

We're then going to move things down to Tobey Oliver and Marc Steinberg who are our appeals and grievance experts, and they're going to be walking through all the different provisions for unified grievances and appeals that we implemented in the Final Rule.

And then because Paul Precht is our main person on D-SNP issues in the office and has been for a number of years, he's going to join the fun and help us answer any questions that you guys have, either after our presentation or in the – in the session that we have, the Q&A session, after we conclude.

Okay. So, there's a lot to unpack here, and you may find this chart to be a helpful synopsis of the new requirements. I'm not going to go through it line by line because that would be boring, but it's mostly here as a reference document to help you understand a couple of things. One of

those things is that – is that not all provisions apply to all D-SNPs. And we will walk through the various provisions and let you know which subsets of D-SNPs certain provisions to. But I wanted to clarify that point.

The other point that I wanted to clarify is that while the BBA-related provisions do apply, as directed by the statute, January 1, 2021, there are a handful of provisions in here that apply sooner. They apply January 1 of 2020, so we'll point those out as we go as well.

Okay. So, I'm going to start off with the integration provisions, and just give you a flavor for what, very high level, what we did in the CFR – in the CFR to make these changes.

The Bipartisan Budget Act of 2018 authorized D-SNPs permanently for the first time since DNSPs became available to beneficiaries in 2006. As part of the deal, though, it also established a variety of new requirements for D-SNPs, including specifically with respect to the integration of Medicare and Medicaid benefits. It raised the bar, so to speak. And those requirements will apply beginning 2021.

In the Final Rule, we – we took the statutory language and tried to simplify that to create three pathways for D-SNPs to essentially prove that they meet one of these integration criteria. So there are three options here. The first two options involve some level of provision of capitated Medicaid Medicaid benefits. So, the plan will in some way have a contract with the state for provision of Medicaid-specific services like long-term services and supports and behavioral health services.

There are two pathways here. The first is for the plan to qualify, meet the requirements as a Fully-Integrated Dual-Eligible SNP, a FIDE SNP. And

the second option would be for the plan to meet the requirements of a Highly Integrated Dual-Eligible SNP. And I'm going to talk a little bit more about what those terms mean, so I'll put a pin in that for now and just also quickly mention, although Marna is going to go into this in a lot more detail than I will, that there is a third pathway. So, for those plans that don't meet that level of integration and don't offer capitated Medicaid benefits, there will be a requirement, via the MIPPA contract, to establish a process whereby the plan or some designee is sharing information with the state or some designee of hospital and skill nursing facility admissions for some group of high-risk enrollees in the plan.

Okay, so I know that talking about definitions is not very exciting, but it's really helpful to helping us set the context for how these requirements apply and to whom. And so I wanted to take a couple of minutes to discuss the different kinds of D-SNPs.

There's been the definition of a D-SNP for some time now, and in the Final Rule we streamlined that definition. The things that remain the same is that a plan that is a D-SNP may cover Medicaid capitated services, and it may not. So, both options remain available. And a D-SNP has to have a MIPPA state Medicaid agency contract. Those things haven't changed.

We've obviously brought the definition up to date with the BBA requirements. And so starting in 2021, one of these three integration options has to be satisfied by the D-SNP.

But one of the other things that we did sort of beyond the BBA provisions is that we clarified in the D-SNP definition the statutory requirement that plans – or D-SNPs specifically – arrange for the provision of Medicaid benefits. Because we thought it was important to codify that language in

such a way as to establish what that expectation actually means. And from our perspective, and sort of complementary to the integration provisions that we're establishing in this Final Rule, what it really means is coordinating the delivery of Medicare and Medicaid benefits.

So, more on this in a minute. I'm going to talk about how this complements a different provision that we established in this Final Rule. But first, I'll walk you through the Fully-Integrated Dual-Eligible SNP provisions because this is essentially the pathway that is – demonstrates, at least in the SNP world, the most integrated option for plans.

FIDE SNPs have been around for a while. The definition has existed, and we have made some changes, both to bring the – the CFR up to date and make it consistent with the BBA, but also to streamline some language and bring in some sub-regulatory clarifications that had not existed in the rules before.

So what's unchanged about a FIDE SNP is that it is a D-SNP that under a single entity has both an MA contract with CMS to offer a D-SNP, and also has a contract with a state as a Medicaid Managed Care Organization to provide Medicaid benefits to its eligible members.

One of the clarifications we made, though, was expanding the language where we refer to long-term care services. We've expanded that to sort of include the sort of broader term of what a FIDE SNP should be providing, which is really long-term services and supports (inaudible), and that includes things like home and community – community-based services.

And also, this is a sub-regulatory requirement that existed in guidance but not in the regs. There is a requirement that the nursing facility services of at least 180 days be provided by all FIDE SNPs.

Now, the HIDE SNP definition is – is new. There had previously been sort of this concept of plan – a D-SNP was a high level of integration that had existed in regs and in guidance, and that really had been focused primarily on these plans' eligibility to offer additional supplemental benefits. So, we haven't changed that, but what we have done is created a definition of what a Highly-Integrated Plan means and made that consistent with the statutory language.

So, compared to a FIDE SNP, a HIDE SNP offers some, you know, relatively high level of integration but, obviously, less than a FIDE SNP. And there are some key differences in terms of that integration level.

The first that I would point to would just be the breadth of the services covered under the capitated contract. The HIDE SNP has the option of offering either LTSS or behavioral health services, it doesn't have to offer them both.

The other major difference that I would point out is sort of the directness of the relationship between the organization that offers the D-SNP and then the organization that offers the Medicaid coverage. That can be more indirect in – in a HIDE SNP. So it doesn't have to be the same organization, it can be an organization that is under the same parent organization umbrella.

So, a few differences, but those, I think, are the two key ones that I would point out.

This is a great chart. I'm not going to run through it line by line. It comes directly from the Final Rule preamble, and it compares FIDE SNPs and HIDE SNPs across a variety of attributes including sort of the directness of that contractual relationship, the kind of Medicaid contract that the organization can have, and then also the – the specific benefits that have to be covered by these.

So, this spans over two pages. Again, it's really here for – for you as a reference.

One of the really important definitions to understand, primarily as it relates to some of the unified appeals and grievances provisions that Marc and Tobey are going to run through, is what it means to have aligned enrollment, right? So this is also a new concept, but it's one that we've been talking about in – in the Dual space for quite some time.

Aligned enrollment occurs when a Dual-eligible individual is enrolled in both a D-SNP and also a companion Medicaid MCO that's affiliated with that D-SNP. Exclusively aligned enrollment is a subset of aligned enrollment. And that occurs when, as a matter of state policy, right, a state has made a decision, the D-SNP enrollees can only be enrolled in that companion MCO for their Medicaid benefits. They don't have the option of getting them through fee-for-service or another organization's MCO. They have to be aligned in order to be enrolled in that D-SNP.

It's relatively rare. I think that exists right now in about eight states, and it's going to be really key for understanding how the grievances and appeals provisions apply.

Okay. I'm going to wrap up just by talking about one more provision. As I mentioned earlier, in the Final Rule we clarified that all D-SNPs must coordinate their Medicare and Medicaid benefits. So for beneficiaries who are entitled to use Medicaid benefits, it's important that the D-SNP be making those connections regardless of how the beneficiary is obtaining those services. So, some of those beneficiaries are going to be getting their Medicaid benefits in fee-for-service. Some are going to be getting their benefits through an MCO that's affiliated with the D-SNP's parent organization. And some are going to be getting their benefits through a different MCO altogether. Or, it can be a combination of those three, right? So we understand that that's complicated.

But as a corollary to that, one of the things that we wanted to do to sort undergird the – the Unified Appeals and Grievances provisions and, you know, ramp up on the coordination requirements, is to establish requirements that all D-SNPs provide assistance to their members with getting Medicaid-covered services to which they are entitled and resolving any coverage or authorization issues that arise with respect to those services.

We also expect D-SNPs to provide assistance with filing Medicaid grievances and – and requesting appeals for Medicaid-covered services.

So starting in 2020, this is a new expectation. D-SNPs are explicitly required to provide this assistance, and that should happen when the plan becomes aware of a beneficiary's need for a Medicaid-covered service. So we would expect D-SNPs to be having contact with their members in a variety of ways. So, there will be health risk assessments, and care planning processes. And as part of that, a member may be identified as needing a very specific Medicaid service, and so our expectation is that

the plan is connecting the beneficiary with that coverage, which will involve asking questions about where that beneficiary gets their coverage and connecting them to those resources as necessary.

So, I think with that, I'm going to hand things over to Marna. She's going to walk you through the rest of the integration provisions.

Marna Metacalf Akbar: Thanks, Vanessa.

Starting in 2021, all D-SNPs that are not contracted as FIDE or HIDE SNPs must include a notification requirement in their state Medicaid contracts. This requirement is intended to advance integration by improving care coordination between the D-SNPs and states during transitions of care, such as an admission to a hospital or a skilled nursing facility. These are times when the coordination of Medicare and Medicaid benefits is crucial.

Our approach in developing this requirement was to give states or plans the flexibility to implement the – this requirement is a manner that best meets their priorities and takes advantage of existing systems and infrastructure. We realize that not all states are in the same position to move towards greater integration, and flexibility in how states and plans can implement this requirement allows them to scale up integration efforts over time.

The regulation we landed on was to require D-SNPs to notify the state of an admission to a hospital or a skilled nursing facility for at least one group of high-risk, full-benefit, dual-eligible individuals.

The D-SNP can determine or designate a provider such as a hospital to complete the notification, but will ultimately be held responsible for ensuring that notification happens.

And similarly, the state may designate a recipient of the notice, such as a Medicaid managed care organization, or Medicaid provider, or anyone who is able to act on that admission information.

The state will also determine which subset of high-risk individuals the notice will be required to be sent for. And ideally that will happen in collaboration with the D-SNPs within that state's market. The – I'd like to go back to that high-risk – high-risk individuals. The state can choose those – can identify high-risk individuals in several different ways. They can be those who are receiving home and community-based services, or using enrollment information, identify beneficiaries who have frequent readmissions. And states can select a small subset of high-risk beneficiaries in order to create a – a notification that wouldn't require automation and perhaps build that up over time. Alternatively, states that have more – more developed infrastructure can use their state contracts to establish a notification for a broader group of beneficiaries.

States will also establish timeframes and methods for the notification, but we, again, strongly encourage them to work with D-SNPs to identify the most efficient notification mechanisms available. And we encourage D-SNPs to reach out to their states to identify approaches to this notification requirement that enhances care coordination for all stakeholders.

And, as we'll be mentioning throughout the presentation today, we will be providing technical assistance and sharing best practices for this notification requirement as we gain more experience.

And now we have a pop quiz to make sure all of those people who are sleepy are paying attention. True or false. All D-SNPs must notify the state of all hospital and SNF admissions.

All right. Well, this is a little bit of a tricky question. It seems that most of you are getting it right. This was a double false. That D-SNPs that are not FIDE and HIDE SNPs will be required to include this notification in their Medicaid contract, so it's not all D-SNPs. And it will not be for all hospital admissions. It will just be for hospital and SNF admissions for that subset of beneficiaries identified by the state as high risk.

Moving on, any D-SNP that does not meet the integration criteria that Vanessa mentioned earlier, being a FIDE or a HIDE SNP, or including the notification requirement in the state contract by the year 2021, will receive a market and enrollment sanction from CMS. And these sanctions will continue until the D-SNP submits a corrective action plan and the criteria of integration are met.

And the last part on contracts. We have another table for you to serve as a reference. That just highlights some of the minor changes that we've made to the contract requirements. These are mainly to improve clarity as well as to align with the new D-SNP definitions.

And I am now going to pass it on over to Tobey Oliver to talk about D-SNP unified appeals and grievances.

Tobey Oliver: Thanks, Marna. Hopefully everybody that was sleepy after lunch has gotten a coffee for the grievance and appeals part.

So the Medicare and Medicaid program systems for grievances and appeals have been separate, and there has been differences in the requirements between the systems historically. The number of differences has decreased over time, including with the Medicaid rule that was finalized a few years ago, but there's still a number of differences, and they're still separate systems, and this has a direct impact on individuals who are enrolled in both programs to the extent that they need to appeal a benefit decision and maybe to understand and navigate the two different systems.

So, the Bipartisan Budget Act of 2018 helps address this issue to some extent by requiring a unified grievance and appeal procedure for D-SNPs to the extent feasible as determined by the Secretary for 2021.

So, the way we finalized the rule is that it will be applicable only to uni – applicable unified – I'm sorry, applicable integrated plans, as Vanessa mentioned earlier. And it will be effective in 2021.

Right. So, some of the differences that still exist between Medicare and Medicaid that we were thinking through as we were developing this unified system include filing and adjudication timeframe differences. So, for example, under Medicaid an enrollee can file a grievance at any time whereas under Medicare they need to file a grievance within 60 days.

Availability of benefits continuing while the appeal is pending. This is something that's available to enrollees only under Medicaid currently where if a plan tells a beneficiary that they are going to reduce or stop a service early, the member can actually ask that the benefit be continued while their appeal is being resolved, and that protection is not currently available under Medicare.

Also the levels or review and availability of an expedited grievance. Expedited grievances are currently only something that's available under Medicare, it's not something that exists currently under Medicaid.

So, as you can probably guess, all these kind of really in-the-weeds differences can be confusing and harmful to enrollees and lead to de-location of activities if an enrollee filed a case under – an appeal under like Medicare and Medicaid for a benefit where really it's only appropriate under one or the other. So it can be duplicative activities for both the individual and for the plan.

So the Bipartisan Budget Act some details in it that we really used as policy principles when we were developing our Unified Appeals and Grievance System. One of which is that we adopt the requirements that are most protective of enrollees. And so an example of how we did this is, as I mentioned earlier, the differences in filing requirements for grievances, in our Unified System we have set it up so that an enrollee can file a grievance at any time like it is under the Medicaid standard because we found that to be more protective for enrollees that they can file any time without having to worry about a deadline.

It needs – the system needs to be compatible with unified timeframes and consolidated access to external review. So we've set up one plan level of review for both Medicare and Medicaid services for the first level of review, with one set of timeframes that apply to the whole process.

We were supposed to take into account differences under state Medicaid plans, i.e., state flexibility. So, this is another difference between Medicare and Medicaid currently. It's not something that really exists

under Medicare currently, but under Medicaid states can currently have different standards. There's the regulation standard under Medicaid, but then states can vary from that to some extent, typically by like shortening a time frame. Instead of giving a plan 30 days to respond to something, shortening it to only giving 14 days to respond on something. So those types of state differences. We were directed to take those into account.

And then also that it should be a system that's easily navigable by enrollees.

So, as we mentioned earlier, this is a unified system that will only be applicable to a subset of D-SNPs. It will be only applicable to FIDE SNPs and HIDE SNPs with exclusively aligned enrollment and the Medi – and also, well, to the Medicaid managed care organization that's aligned with that HIDE SNP or FIDE SNP. So, the most important takeaway is that it will only be applicable to plans that have exclusively aligned enrollment under their state policy.

So, as Vanessa mentioned, there's currently only eight states and 37 D-SNPs that would fall into this category, so a relatively small number of plans will be impacted, but we hope that will be a growing number over time.

So, next we have another polling question to see if you were paying attention. We should have warned you up front there would be tests.

My organization operates at least one applicable integrated plan. So, you have to have – follow my definition and our description and also know what kind of plan you're coming from.

Well, being there are only eight states and 37 plans, we kind of expect the number not to be too high, but I – I'm impressed. There are more – more saying yes we do than I kind of expected.

That was selection bias, right. They're the ones that are paying attention. That's true. You're the ones that are paying attention. That is true.

So with that, I'm going to turn things over to Marc.

Marc Steinberg: Okay, thank you, Tobey. Well, if you're not awake yet, you'll definitely be by the time I am done. The details of the Integrated Grievance and Appeal process.

I'm going to spend just a few minutes going through some of the – some of the details. Obviously there's a lot more in the Final Rule and in the preamble, and if you haven't reviewed it already, we encourage you to. And there's going to be more guidance and other materials coming out.

But, basically, when you look – when you review the rule, you'll see we've set up specific language that borrows from both the Medicare and Medicaid rules and makes some harmonization to set up a single grievance process, as Tobey alluded to, so we identified the timelines and the grievance procedures.

We've also integrated the coverage determination process and the plan-level appeals process. And those are at – you'll see these are new sections of the CFR, 422, 630, 631, and 633.

One of the reasons I think this is going – we are very optimistic this is going to b helpful for beneficiaries and plans is in this coverage determination and reconsideration process, the integrated plan applies both Medicare and Medicaid criteria. And if any of you have worked in this world, you know things like home health and DME in particular, you've got Medicare criteria, you've got Medicaid criteria, and the member doesn't know which criteria applies to them. The idea here is that there is one consideration, the plan looks at both coverage criteria and determines if there is or is not coverage under one or the other. And because this is an integrated product, there's not the same level of confusion or concern.

As well as there's one set of timelines to the plan. Doesn't have to worry about am I on this timeline or that timeline, there's just one.

And we set rules for who can represent and who are the parties, looking at some very nitty-gritty differences between Medicare and Medicaid. Who can request an appeal and when, and we tried, and I think we succeeded, finally, after some very helpful comments during the comment process, at getting a – a rule that brings together Medicare and Medicaid rules in the best way to protect beneficiaries and keep a manageable system.

One of the areas where integration needs to make a big difference is in the notice area. The statute, the Bipartisan Budget Act, tells us that we need to have a single written notification of all grievance and appeals rights. We're working on developing model notices and instructions. And we're relying heavily on the experience we've had with the financial alignment initiative. These are the Medicare-Medicaid plan Duals demonstrations you may – some of you may participate in, others have no doubt heard of, where we have been integrating Medicare-Medicaid

now for, I guess, what are we, 2019, so five years. So we've relied a lot on the experience we've had in that in starting to work on our notices.

In particular, there will be one integrated denial notice that will be – it's based in part on the current MA ID and/or making some changes. And it's described in the – in the reg at 631(d)(1).

The model is going to be beneficiary tested, and then it will go through the Paperwork Reduction Act process, which means everyone here will have – everyone who is interested – will have an opportunity to comment on it. And that will probably be this time – later in 2019. Right, Marna? That's the target?

So keep your eyes out for that opportunity to comment on the model notice. We really want comments. We are trying to make this a beneficiary-friendly and functional notice and want to make it – we really want to make it as good as possible. We are biting the advice both from the statute – or instructions from the statute and advice received from everyone to make it an easy, plain-language notice. Something that people can understand the status of their grievance and appeal from. So, you know, again, this is an area where we are looking for help from everyone to make something that works for all stakeholders.

One of the key areas, again, where we are – this is a change from existing Medicare practice, and my colleagues already alluded to it, is the continuation of benefits while the appeal is pending. Just for a bit of context since this is primarily a Medicare audience, the notion of benefits pending appeal is very well established in Medicaid. The idea is that if you have a service that is ongoing, and your plan, or in Medicaid it's often the state agency, wants to make a change, a reduction, they give you

advanced notice, and if you have – if you appeal within a certain period of time, typically ten days of receiving the notice, you can keep that coverage going during your appeal. The idea being that someone with very limited financial resources would be – could – is unable to pay out of pocket during – while an appeal is pending. And so the protection of the law recognizes that and says you can keep your services while you are contesting your – your – the change in your services.

And the statute directed us to carry that – that protection into the Medicare ongoing – the Medicare benefits which are primarily limited to ongoing services. So this is a big change in law, although I think at an operational level, based on our experience, we have done this in Medicare-Medicaid plans, in the financial limit demonstrations. It's, again, there are not that many ongoing Medicare services compared to Medicaid. In Medicaid you think of things like personal care that goes on and on, and there's changes in your hours and things like that. Medicare, you know, a – an office visit is not an ongoing service. You don't have, you know, there's something – or a test that you are asking for prior authorization is not an ongoing service.

But there are some changes. And especially it will just simplify matters. You don't have to figure out if this is a service that I can get benefits continuing or not.

And we – that – this protection isn't going to be part of the model notices. It's something that we certainly plans are going to have to think about how are they going to deliver it. Again, it's something that if you have worked in the Medicare-Medicaid plan world, the financial limit world, you're familiar with it. And those of you who have products in that area, I encourage you to look at their experience. We have not heard, really, any

complaints from any plans in the MMP world about this – this provision. So, we're hopeful it will be a simple and helpful change.

Finally, this is a short section. Regulation 634 points out that subsequent to this integrated plan of review, all the Medicare and Medicaid review that we're all familiar with stays in place. So, the appeals basically bifurcate after that point. We talked about in the proposed rule that we are interested in looking at ways to integrate subsequent to the plan level, but we've still got a lot of legal and policy challenges. We've got to figure out, so for Medicare-related service after a plan-level integrated review, it will go through the regular medical review, the IRE, and then if appropriate to an ALJ and possibly appeals counsel.

Medicaid, the same state fair hearing rules exist and any other state rules.

Okay. This is your last survey question. This is a question – the question is, all D-SNPs must adopt integrated grievance and appeals processes by 2021. It's a yes or no, true or false.

All right. Remember the question – I'll give you a hint. The question is all D-SNPs. And is it – is it all D-SNPs or is it a group of D-SNPs? Yeah, now we're trending in a better direction. There you go.

(Inaudible.)

Right. So, remember, we are talking about what we've – what we call in the rule Applicable Integrated Plans will have to adopt this. And generally these are – and there's about eight states, about 37 plans right now. We think that number will probably grow. These are, as we talked about,

plans where someone, if the state requires, enrollment in both the Medicare and Medicaid product. And we talked about this in the – in both the preamble – in both the proposed and Final Rule. We just could not get our minds around how you could do integrated process if someone is in one plan for Medicare and either a Medicaid fee-for-service or a different plan for Medicaid. Some day maybe we'll figure that out, but this is where we're starting and – and this is what we felt the best way to apply the statute was for now.

Okay. That is all on appeals specifically. This is the wrap up where we nag you to get started on – on your jobs. And we take turns doing this, so it's my turn today.

2021 is not that long from now, especially in the – in the sort of policy and – and operational world. So, it is incumbent on everyone who works in the D-SNP world, all of us at CMS, everyone in the states as well, to start planning now. If you have a D-SNP product, regardless of whether it's an applicable integrated plan, any D-SNP product, should be talking to the states you work with. As Marna was talking about, there are these notification requirements where there's a lot of state flexibility. There's an opportunity for you all to talk to the states about what kind of notification makes sense. What entities should be notified. So, you know, get – get on – get in touch with the state Medicaid agencies.

Revisions to the contracts have to be made by July 2020, so not tomorrow, and not this year because this is this year's contract. But as soon as this year's contracts are done, we are expecting, you know, states, and us, and everyone to really start engaging on this.

If you are an applicable integrated plan, or you operate one, then there are operational changes you're going to need to make for these unified grievance and appeals procedures, so it's time to start thinking of what does that encompass.

We are here to help. We are working on sub-regulatory guidance. There will be memoranda. We're going to be updating a number of manual chapters to reflect these rules. So stay tuned for that. We certainly want feedback on that as well.

And some of you may be familiar with our contractor, the Integrated Care Resource Center. If not, I certainly encourage you to check them out. Their target audience is states, state Medicaid agencies looking to integrate. A lot of the information is extremely relevant to all of you who operate D-SNPs as well. We're working with them to provide states, as well as to you, with best practices for sharing information, as Marna was talking about. What do we – this information about inpatient hospital admission, where should it go? Who should use it? What's the best way to use it? What's the best practices for getting D-SNP information about enrollees' Medicaid coverage? We know during the comment process we got a lot of comments saying this is very difficult in a number of states, and certainly we look forward to making – making that better.

We're going to be working on model contract languages for your state contracts. And states can get technical assistance there as well, and they put out a lot of great material, so we encourage you to look at them. I think we provide – yep – the link right here. So this is the – this is just for further investigation. We have the text of the rule there. Encourage you all to look at that if you haven't already.

The Integrated Care Resource Center, ICRC, website is there. Definitely take a look if you haven't already.

And then, questions you can send to us.

I think that is all, right? And we have seven minutes for questions, so we're great.

Stacey Plizga: All right. We do have a couple minutes for questions, so if there is anybody in the audience that has a question, please go ahead and step up to the microphone, tell us your name and where you're from.

Bless you.

Sarah Triano: Hello. I'm Sarah Traino with Centene, and I have a question. Actually I have four questions, but I'll wait – I'll get in line after everybody else does.

In geographies with overlapping MMPs and D-SNPs, which takes precedence, passive enrollment into the MMP or default enrollment into the D-SNP?

Paul Precht: I'm not sure I – I got the question.

Sarah Triano: So if you have a certain geographic area where you have D-SNPs that exist but you also have an MMP.

Paul Precht: Yes.

Sarah Triano: MMPs have passive enrollment, and if that D-SNPs has autho – has in their contract is allowed to do default enrollment, which one takes priority?

So –

Who gets the member?

Paul Precht: So that's really a – a state decision. So the state has to provide approval, you know, for default enrollment into any D-SNP. And they also work with us in terms of passive enrollment into the MMP and where they will be drawing from. So, it's really – it's contingent on the state. (Inaudible)

Marc Steinberg: No, you're right completely (inaudible). The states – and we work with the states. If a state decides to exclude, say, D-SNP enrollees from passive enrollment, we can do that. We've done that in a couple states, I think. And then, so it's something that we work out with the states. Some states have, I guess have permitted it, but – have actually drawn from – have they drawn from D-SNPs? I don't think anyone has drawn from the D-SNP. But, like Illinois decided basically to push everyone towards MMPs, and that's permissible as a policy decision, but it's done deliberately. We would – it's done in consultation with CMS.

Stacey Plizga: I think you're up again.

Sarah Triano: Okay, I'll keep going. I really appreciate the efforts to integrate the grievance and appeals process. My question is, is CMMI or CMS doing any kind of test – any kind of – anything to test the alignment of the assessment process, particularly for unaligned Duals.

Tobey Oliver: Like the risk assessment?

Sarah Triano: Yeah, or for, say, somebody who's receiving Medicaid MLTSS where they go through a very extensive assessment process. And so – and there's also assessments, you know, part of the coordination required for D-SNP, so is there anything to kind of align that better so that those members are not going through multiple assessments? The ones who have chronic conditions.

Paul Precht: So – so I understand the issue, and it's – it's on our plate. It's complicated to address because the plans have specific needs for their health risk assessments. And states also have certain requirements. But we're well aware of the problem. But it's not – it's not easy to solve because of all the – the players that are out there. But we – we would be happy to talk to you more about any ideas that you have along those lines.

Sarah Triano: Sure. That's on our wish list.

Stacey Plizga: You're still up.

Sarah Triano: Okay. I have one last question, and that is do the interoperability proposed rules also apply to D-SNPs? Pace organizations are exempt. Just wondering if D-SNPs are exempt as well.

Vanessa Duran: I'm not sure we have the right folks here to discuss the interoperability rule, which is currently still in a drafting stage. So you can send us that question and we can try to find an answer, but –

Sarah Triano: Okay. Thank you.

Stacey Plizga: And we do have another question.

Michelle Ford: Hi. Michelle Ford at Medicare Compliance Solutions. So for the – all the D-SNPs who are not – do not fall under the eight states and the 37 plans, is there any – are there any efforts to help those members navigate the really confusing appeals and grievance process currently?

Paul Precht: Well, I mean, there – and I think we talked about this. The D-SNPs, under their obligation to – so those D-SNPs that are not – they don't have all their members also in – the same Medicaid plan, they have an obligation to help coordinate those Medicaid services, and that includes an obligation to help, you know, them – their members to navigate the Medicaid process, the Medicaid grievance process, Medicaid appeals process, to get – and to figure it out. It's not enough for them to say somebody seeks a Medicaid benefit and they only provide Medicare benefits. It's not enough for them to say, sorry we don't do that. They have to help their member access those benefits.

Michelle Ford: And then a second question we have is, the – is CMS working with the states to allow more MAPD plans to have Medicaid contracts?

Paul Precht: So – well, what we're doing through the Integrated Care Resource Center is to provide states with information on the benefits of integration including integration on the D-SNP platform. That is, you get somebody – if you're using managed care for delivery of your Medicaid benefits, in particular managed long-term services and supports, there are real benefits from integrating that with the provision of Medicare benefits. So the medical and the long-term care are integrated. But it is up to the state to decide whether they want to go that route and whether they want to contract with a D-SNP or not.

Marc Steinberg: Right. I mean, there's some states that are not – that are not going down the managed care path as much on their Medicaid program, and so it's – they need to look at different models for – for integration. And we look – and are eager to talk with them, too, but this is not the platform for that. And that's okay, too. We have 50 states.

Michelle Ford: Yeah. Thank you.

Stacey Plizga: Okay, well we are out of time for questions for this session, so I would like to thank our panel for the clarification on the new rules related to D-SNP. Thank you.

[applause]

All right, so if you'd like to evaluate this session, go ahead and take those phones out and enter A, send, and then go ahead and follow that link. And enter your responses.

While you are doing that, I will introduce our next session.