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CMCS Informational Bulletin

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SUBJECT: Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for State Medicaid Agency Contracts with Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) for Contract Year 2021

Introduction

Dual Eligible Special Needs Plans (D-SNPs) are Medicare Advantage (MA) plans that are specifically designed to integrate and coordinate care for dually eligible individuals by focusing on enrollment and care management for this population. As of September 2019, approximately 2.7 million dually eligible individuals (one out of every five dually eligible individuals) were enrolled in one of the 480 D-SNPs.[1]

The Bipartisan Budget Act (BBA) of 2018 strengthened D-SNP Medicare-Medicaid integration requirements and unified Medicare and Medicaid grievance and appeals procedures for some D-SNPs beginning in 2021. On April 16, 2019, CMS finalized rules (hereafter referred to as the April 2019 final rule) implementing these new statutory provisions.[2] States play an important role in D-SNP implementation of these requirements. This bulletin contains information for states to consider when updating their Contract Year (CY) 2021 contracts with D-SNPs (submitted to CMS in July 2020). This bulletin also highlights important information that states need to ensure that D-SNPs in their markets meet the new requirements beginning in CY 2021. **We strongly recommend states use the information in this bulletin to engage with D-SNPs on these new requirements as soon as possible.**

Background

Beneficiaries dually eligible for Medicare and Medicaid can face significant challenges in navigating the two programs, which include separate or overlapping benefits and administrative processes. Fragmentation in care delivery can result in a lack of coordination, which may lead to:

[1] Centers for Medicare & Medicaid Services (2019, September). *SNP Comprehensive Report*. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html.

[2] *See:* CMS-4185-F, the "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" final rule. Retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

(1) missed opportunities to provide appropriate, high-quality care and improve health, and (2) undesirable outcomes, such as avoidable hospitalizations and a poor beneficiary care experience. Misalignments between Medicare and Medicaid also can result in weakening safeguards for beneficiaries. For example, the grievance and appeal processes for both programs take broadly similar approaches, but operate independently with subtle misalignments. For dually eligible individuals, these separate processes result in confusion over which program is covering an item or service and how to file a grievance or appeal.

Advancing policies and programs that integrate processes and care for dually eligible individuals is one way in which CMS seeks to address this fragmentation. As discussed in our December 19, 2018, State Medicaid Director Letter, "Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare," [3] there are several ways in which states are currently using the D-SNP platform to advance such integration, including requiring that Medicaid managed care organizations (MCOs) offer an affiliated D-SNP. This approach – used by a number of states, including Arizona, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, New Mexico, Pennsylvania, Tennessee, and Virginia – requires Medicaid MCOs serving dually eligible individuals to offer an affiliated D-SNP. This ensures that these enrollees have the option of receiving the full array of Medicare and Medicaid benefits through a single delivery system, thereby improving care coordination, quality of care, and beneficiary satisfaction, and reducing administrative burden.

Medicaid MCOs that have an affiliated D-SNP that is offered by the same organization and meets other CMS requirements regarding provision of Medicaid benefits are known as fully integrated D-SNPs (FIDE SNPs), described in more detail in the "Integration Requirements" section of this bulletin. Highly integrated D-SNPs (HIDE SNPs) are less integrated but provide coverage of Medicaid long-term services and supports (LTSS), behavioral health services, or both, under a capitated contract between the state Medicaid agency and the MA organization, the MA organization's parent organization, or another entity owned by the MA organization or its parent organization.

While there is mounting evidence that highly integrated managed care programs perform well on quality of care indicators and enrollee satisfaction,[4] the majority of D-SNP enrollees are not enrolled in these highly integrated arrangements. The new D-SNP requirements added by the

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[3] *See:* https://www.medicaid.gov/federal-policy-guidance/downloads/smd18012.pdf

[4] *See:* Kim, H., Charlesworth, C.J., McConnell, K.J., Valentine, J.B., and Grabowski, D.C. (2017, November 15). *Comparing Care for Dual-Eligibles Across Coverage Models: Empirical Evidence From Oregon*. Retrieved from http://journals.sagepub.com/doi/abs/10.1177/1077558717740206; Anderson, W.L., Feng, Z., & Long, S.K. (2016, March 31). *Minnesota Managed Care Longitudinal Data Analysis*, prepared for the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE). Retrieved from https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis; Health Management Associates (2015, July 21). *Value Assessment of the Senior Care Options (SCO) Program*. Retrieved from http://www.mahp.com/wp-content/uploads/2017/04/SCO-White-Paper-HMA-2015_07_20-Final.pdf; and Medicare Payment Advisory Committee (2012, June 16). "*Care coordination programs for dual-eligible beneficiaries*." In June 2012 Report to Congress: Medicare and Health Care Delivery System. Retrieved from http://www.medpac.gov/docs/default-source/reports/chapter-3-appendixes-care-coordination-programs-for-dual-eligible-beneficiaries-june-2012-report-.pdf?sfvrsn=0.

BBA of 2018 present new opportunities for states to further Medicare and Medicaid integration using D-SNPs as a platform.

Summary of New D-SNP Requirements

We summarize the D-SNP requirements that CMS codified in the April 2019 final rule below.

Integration Requirements

Starting in CY 2021, D-SNPs must meet the new Medicare-Medicaid integration criteria in at least one of the following ways listed in the table below:

Three Ways of Meeting the D-SNP Integration Requirements	
1. D-SNP meets CMS requirements to be designated as a FIDE SNP	Provides Medicare and Medicaid benefits under a single entity that: • Has an MA contract with CMS; and • Has a Medicaid MCO contract with a state; • Has coordinated care delivery and coordinates or integrates certain administrative functions; and • Provides coverage, consistent with state policy, of Medicaid benefits, including: o Long-term services and supports (LTSS); and o Nursing facility services for at least 180 days per plan year
2. D-SNP meets CMS requirements to be designated as a HIDE SNP	Provides Medicare benefits and: • Has an MA contract with CMS; and • Provides coverage of Medicaid LTSS **and/or** behavioral health services, consistent with state policy, under a capitated contract between the state Medicaid agency and: o The MA organization; or o The MA organization's parent organization; or o Another entity owned by the MA organization/parent organization
3. D-SNP notifies the state (or state designees) of hospital or SNF admissions for at least one group of high risk enrollees	Has a contract with the state that specifies a process for notifying the state, or the state's designee(s), of hospital or skilled nursing facility (SNF) admissions for at least one designated group of high-risk individuals, for the purpose of care coordination of Medicare and Medicaid covered services during a transition of care. The state Medicaid agency must establish the timeframes and method(s) by which notice is provided.

States whose D-SNPs provide enrollees with capitated Medicaid benefits – either directly or indirectly – may be particularly interested in the table below, which provides more detail on the similarities and differences between FIDE SNPs and HIDE SNPs. States can make substantial progress toward integrated care using the D-SNP platform whether they contract with FIDE SNPs or HIDE SNPs. However, one key difference between FIDE SNPs and HIDE SNPs beyond their level of integration is that FIDE SNPs may qualify for a frailty adjustment to their Medicare payment from CMS if specific criteria are met, whereas HIDE SNPs are not eligible for that payment adjustment.

Attributes of FIDE SNPs and HIDE SNPs		
	FIDE SNP	**HIDE SNP**
Must have a contract with the state Medicaid agency that meets the requirements of a managed care organization as defined in section 1903(m) of the Act.	Yes	No
May provide coverage of Medicaid services via a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP).	No	Yes
Must provide coverage of applicable Medicaid benefits through the same entity that contracts with CMS to operate as an MA plan.	Yes	No. The state Medicaid contract may be with: (1) the MA organization offering the D-SNP; (2) the MA organization's parent organization; or (3) another entity owned and controlled by the MA organization's parent organization.
Must have a capitated contract with the state Medicaid agency to provide coverage of LTSS, consistent with state policy.	Yes	No, if the capitated contract otherwise covers behavioral health services.
Must have a capitated contract with the state Medicaid agency to provide coverage of behavioral health services, consistent with state policy.	No. Complete carve-out of behavioral health coverage by the state Medicaid agency is permitted.	No, if the capitated contract otherwise covers LTSS.
Must have a capitated contract with the state Medicaid agency to provide coverage of a minimum of 180 days of nursing facility services during the plan year.	Yes	No

Unified Appeals and Grievance Processes

Certain D-SNPs and affiliated Medicaid managed care plans – specifically, those with "exclusively aligned enrollment" as described in more detail in the "Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment" section of this bulletin – must implement unified Medicare and Medicaid grievance and plan-level appeals processes starting in CY 2021. For these plans and their enrollees, implementation of the requirements in the April 2019 final rule will provide simpler, more straightforward grievance and appeals processes.

State Medicaid Agency Contract and Operational Changes

All D-SNPs must have executed contracts with applicable state Medicaid agencies, sometimes referred to as the "State Medicaid Agency Contract" (SMAC). This section describes the D-SNP contract with the state and operational changes D-SNPs need to implement, in collaboration with state Medicaid agencies, to operate in CY 2021 and beyond. The first subsection describes requirements that apply to all D-SNPs. Subsequent subsections describe requirements that apply only to certain subsets of D-SNPs.

Requirements for all D-SNPs

D-SNPs are required to submit to CMS a contract with each state in which they seek to operate for the upcoming contract year by the first Monday in July.[5] CY 2021 contracts must be submitted to CMS by July 6, 2020. The April 2019 final rule revised some of the minimum state contract requirements that apply to all D-SNPs and added new requirements for some D-SNPs.

To comply with these requirements for CY 2021, D-SNPs will need to work with state Medicaid agencies in advance of July 2020. (See the "Key Dates for States" section of this bulletin for more information.) The table below highlights these changes to the minimum state contract elements.

The state D-SNP contract must document:
1. ***Revised:*** The D-SNP's: (1) responsibility to coordinate the delivery of Medicaid benefits; and (2) if applicable, responsibility to provide coverage of Medicaid services.
2. ***Revised:*** The category(ies) and criteria for eligibility for dually eligible individuals to be enrolled under the D-SNP (e.g., conditions of eligibility under Medicaid, such as nursing home level of care and age or requirement for D-SNP enrollees to enroll in a companion Medicaid plan to receive their Medicaid services).

[5] For further information see: Integrated Care Resource Center, *Update on State Contracting with D-SNPs: The Basics and Meeting New Federal Requirements for 2021* (July 2019). Retrieved from: https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-snps-basics-and-meeting-new-federal-requirements-2021

The state D-SNP contract must document:
3. ***Revised:*** The Medicaid benefits covered under a capitated contract between the state Medicaid agency and the MA organization offering the D-SNP, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization.
4. The cost-sharing protections covered under the D-SNP.
5. The identification and sharing of information on Medicaid provider participation.
6. The verification of enrollees' eligibility for both Medicare and Medicaid.
7. The service area covered by the D-SNP.
8. The contract period for the D-SNP.
9. ***New:*** For a D-SNP that is not a FIDE SNP or HIDE SNP, a requirement for notification of hospital or SNF admissions for at least one designated group of "high risk" enrollees (see the "Information Sharing Requirements for all D-SNPs except FIDE SNPs and HIDE SNPs" section of this bulletin for more information).
10. ***New:*** For a D-SNP that is an applicable integrated plan, a requirement for the use of the unified appeals and grievance procedures (see the "Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment" section of this bulletin for more information).

Information Sharing Requirements for all D-SNPs except FIDE SNPs and HIDE SNPs

D-SNPs that do not contract with a state as FIDE SNPs or HIDE SNPs must include the additional minimum state contract requirement to specify a process to share information on hospital and SNF admissions starting for CY 2021. For the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the D-SNP contract with the state must describe:

- The process whereby the D-SNP notifies, or arranges for another entity or entities to notify, the state (and/or the state's designees) of hospital and SNF admissions for at least one group of high-risk full-benefit dually eligible individuals, identified by the state;

- The timeframe and methods by which such notice is provided; and

- The criteria for identifying the high-risk full-benefit dually eligible individuals for whom the notice is provided.

The April 2019 final rule provides substantial flexibility for states. We encourage states to implement the notification requirement in a manner that increases care coordination during transitions of care and builds on current infrastructure. Examples of state flexibility include:

- Choosing the manner in which notification occurs and how data is exchanged. For example, in markets where there is existing infrastructure to leverage, such as a state health information exchange (HIE), a state may elect an approach that requires data sharing across a common platform.

- Identifying the group of high-risk full-benefit dually eligible individuals for which the requirement applies. For example, states can focus on dually eligible individuals that receive home and community-based services, behavioral health services, or LTSS. There is no minimum or maximum size for the group of high-risk enrollees the state identifies.

- Choosing which entity(ies) receive the notification. For example, a state could require that a D-SNP meet the notification requirement by notifying a Medicaid MCO that serves dually eligible beneficiaries, a Medicaid health home, or a home and community-based services care coordinator.

States can require a similar notification for FIDE SNPs and HIDE SNPs in the contract; however, this contract element is not necessary for FIDE SNPs and HIDE SNPs to meet Medicare-Medicaid integration criteria.

Action Items for States: States can use the information on minimum state contract requirements in this bulletin to ensure any contract entered into with a D-SNP meets these revised standards.

We also encourage states to engage stakeholders and relevant D-SNPs as soon as possible to identify the most cost effective and least burdensome approaches and processes for the notification requirement that facilitate care coordination. CMS provides technical assistance to states by sharing best practices for this notification, including the resources highlighted at the end of this bulletin.

Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment

A subset of FIDE SNPs and HIDE SNPs with exclusively aligned enrollment must implement the unified appeals and grievance procedures described in 42 CFR 422.629 – 634 beginning in 2021. In the regulations, we refer to these plans as "applicable integrated plans," defined at 42 CFR 422.561 as FIDE SNPs or HIDE SNPs with exclusively aligned enrollment, where state policy limits the D-SNP's membership to a Medicaid managed care plan offered by the same organization. (In addition, the Medicaid MCO that covers Medicaid benefits for the dually eligible individuals in the FIDE SNP or HIDE SNP with exclusively aligned enrollment is also an applicable integrated plan subect to the unified appeals and grievance procedures under 42

CFR 438.210 and 438.402.) In such plans, one organization is responsible for managing Medicare and Medicaid benefits for all D-SNP enrollees.

The contracts with the states for these plans must include a requirement that the D-SNP uses the unified appeals and grievance procedures under 42 CFR 422.629 – 422.634, as well as conforming Medicaid managed care rules at 438.210, 438.400, and 438.402. As specified in the April 2019 final rule, states have the discretion to implement standards different than those established in the final rule if the state standards are more protective for enrollees, such as shorter timelines for a plan to make a decision on an appeal (see 42 CFR 422.629(c)). Where states use this discretion and implement standards different than those in 42 CFR 422.629 – 422.634, the state must specify its requirements in the D-SNP contract.

Action Items for States: For states with D-SNPs subject to the new requirements, beginning work to specify any state-specific standards in the D-SNP contract is crucial in order to provide D-SNPs with notice of these standards and to ensure that we hold D-SNPs to the correct standards. States should also consider specifying the additional requirements for unified grievances and appeals from 42 CFR 422.629 through 422.634, 438.210, 438.400, and 438.402 in the Medicaid MCO contracts for the applicable integrated plans.

Key Dates for States

All D-SNPs are required to submit a new contract with the state (or an evergreen contract with a contract addendum) to CMS for each state in which they seek to operate in for CY 2021 by July 6, 2020. This includes, as applicable, the new contract requirements identified in 42 CFR 422.107(c) and (d) and summarized in this bulletin. **Unlike in prior years, D-SNPs with an evergreen contract cannot exclusively rely on the submission of a letter of good standing with a previously executed contract from their respective states to demonstrate compliance with 42 CFR 422.107. Therefore, we strongly encourage states and D-SNPs to begin discussing contract updates as soon as possible.** The table below provides key dates and activities for states and D-SNPs related to compliance with the new requirements.

Month/Year	Activity
Fall 2019	• States and D-SNPs begin drafting changes needed to ensure state contracts meet new requirement • States plan for any needed MCO contract changes
Winter 2020	• States and D-SNPs identify and create any new policies and procedures needed in response to contract changes
January 2020	• CMS releases Contract Year 2021 MA (SNP) applications
February 2020	• SNP applications (including SNP service area expansion applications) due to CMS

Month/Year	Activity
Spring 2020	• States and D-SNPs finalize state contracts
June 2020	• D-SNPs not renewing MA contracts notify CMS in writing
July 2020	• D-SNPs submit state contracts and related documents to CMS by July 6, 2020
July/August 2020	• D-SNPs work with CMS and states to address deficiencies in contracts
Summer 2020 - Fall 2020	• States and D-SNPs finalize policies and procedures for CY 2021
August/September 2020	• CMS sends D-SNP approval letters • D-SNPs provide Annual Notice of Change and Evidence of Coverage (including information about any changes to grievances and appeals procedures for applicable integrated plans) to current enrollees
January 1, 2021	• Effective date for most April 2019 final rule provisions

Resources

The CMS Medicare-Medicaid Coordination Office (MMCO) works across CMS and with states to better serve dually eligible individuals, including through efforts to better align the Medicare and Medicaid programs through integrated service delivery under D-SNPs. We are committed to providing technical assistance to states and D-SNPs to help with implementation of these new requirements. MMCO sponsors the Integrated Care Resource Center (ICRC) to provide state-specific assistance to better understand the state's dually eligible population, assess options for improving integration of care, and navigate aspects of the Medicare program that states can leverage to benefit Medicaid. To learn more and to contact ICRC, please visit http://www.integratedcareresourcecenter.com. ICRC and MMCO welcome additional feedback or questions on program requirements from states, health plans, and other stakeholders.

The resources listed below are currently available from CMS and ICRC:

- MMCO D-SNP Webpage: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/D-SNPs.html.

- Update on State Contracting with D-SNPs: The Basics and Meeting New Federal Requirements for 2021 (https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-snps-basics-and-meeting-new-federal-requirements-2021) provides an

overview of state strategies for contracting with D-SNPs to improve care coordination and Medicare-Medicaid alignment for dually eligible enrollees. Special attention is given to new federal D-SNP integration standards for 2021 contract year, and how states can help plans to meet these requirements.

- Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations (https://www.integratedcareresourcecenter.com/resource/promoting-information-sharing-dual-eligible-special-needs-plans-improve-care-transitions) examines the approaches used by three states to develop and implement information-sharing processes for their D-SNPs that support care transitions. The brief includes examples of contract language and strategies to encourage plan collaboration and problem solving around information sharing. It can help states, D-SNPs, and other stakeholders assess how to meet the new D-SNP contracting requirements and improve the care of dually eligible individuals.

- Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plan Enrollees: Key Questions for State Implementation (https://www.integratedcareresourcecenter.com/resource/information-sharing-improve-care-coordination-high-risk-dual-eligible-special-needs-plan) offers key questions and considerations that states can review as they begin working with D-SNPs and other parties to design and implement information-sharing requirements. This technical assistance tool includes sample contract language.

- Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans (https://www.integratedcareresourcecenter.com/resource/sample-language-state-medicaid-agency-contracts-dual-eligible-special-needs-plans) provides sample language that states can use in their D-SNP State Medicaid Agency Contracts that is designed to comply with CMS requirements.

More Information

For more information, please contact the Medicare-Medicaid Coordination Office at MMCO_DSNPOperations@cms.hhs.gov.