

Working with Medicare
Update on State Contracting with D-SNPs:
The Basics and Meeting New Federal
Requirements for 2021

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Speakers



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Agenda

- **Introduction**

- History and purpose of Dual Eligible Special Needs Plans (D-SNPs)
- Benefits covered through D-SNPs

- **Basics of State Contracting with D-SNPs**

- Minimum contract elements
- Achieving aligned enrollment

- **New D-SNP Integration Requirements**

- Fully and Highly Integrated Dual Eligible Special Needs Plans (FIDE and HIDE SNPs)
- Information sharing
- Grievances and appeals
- Timeline

Objectives

- Explain what D-SNPs are, how they are different from other types of Medicare Advantage (MA) plans, and how they can be used to advance integrated care for dually eligible beneficiaries
- Summarize minimum elements for D-SNP contracts
- Explain what new integration requirements will mean for state contracts with D-SNPs; and
- Describe next steps for states to help D-SNPs meet the new integration requirements by 2021

Introduction

What are Dual Eligible Special Needs Plans (D-SNPs)?

- A type of Medicare Advantage (MA) managed care plan
- Authorized in 2003 and began operating in 2006
 - Required to have contracts with states as of 2013
 - Made permanent by Bipartisan Budget Act of 2018
- Enroll only dually eligible beneficiaries (people eligible for both Medicare and Medicaid)
 - For information about who qualifies as “dually eligible,” see “Dually Eligible Individuals – Categories”
<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf>

How are D-SNPs Different from Other MA Plans?

Feature	Non-SNP MA	D-SNP
State Contracting	None	Must have a contract with the state that includes at least certain minimum elements (described later in presentation)
Coverage of Medicaid Benefits	None	Depends on state contract; ranges from no covered Medicaid benefits, to coverage of Medicare cost-sharing and/or wrap-around Medicaid benefits, to all Medicaid covered benefits including long-term services and supports (LTSS) and behavioral health
Level of Medicare and Medicaid Alignment	None	<ul style="list-style-type: none"> • Responsibility to at least coordinate delivery of Medicare and Medicaid services • May include option for beneficiaries to enroll in affiliated D-SNPs and Medicaid plans operated by the same company (“aligned enrollment”) • Plans with aligned enrollment may also integrate Medicare and Medicaid enrollment, beneficiary materials, appeals, etc.

Special Features of D-SNPs

- Can better coordinate care for dually eligible beneficiaries than fee-for-service Medicare/Medicaid or other MA plans
 - Coverage for or coordination of Medicaid benefits, especially LTSS
 - D-SNPs are responsible for acute care costs, which incentivizes stabilization of beneficiary care and conditions and avoidance of unnecessary hospitalization
 - Like other MA plans, D-SNPs may provide supplemental benefits (for example, transportation, dental, hearing, vision, etc.) that may improve access to care for dually eligible beneficiaries
- Through state contracts with D-SNPs, state Medicaid agencies have enforced requirements that enhance integration and coordination of Medicare and Medicaid benefits

Special Features of D-SNPs *(continued)*

All Special Needs Plans (SNPs) must have a **Model of Care (MOC)**

- Framework for how SNP will meet specific needs of enrollee population; must be approved by National Committee for Quality Assurance (NCQA)
- Describes how the plan will assess beneficiary needs; develop individualized care plans (ICPs); establish and utilize integrated care teams (ICTs); and coordinate care, including during care transitions
- Additional requirements include quality measurement and performance improvement plans, measuring goals and health outcomes, and measuring beneficiary experience of care
- SNP MOC elements and scoring criteria described in chapter 5 of the Medicare Managed Care Manual: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c05.pdf>

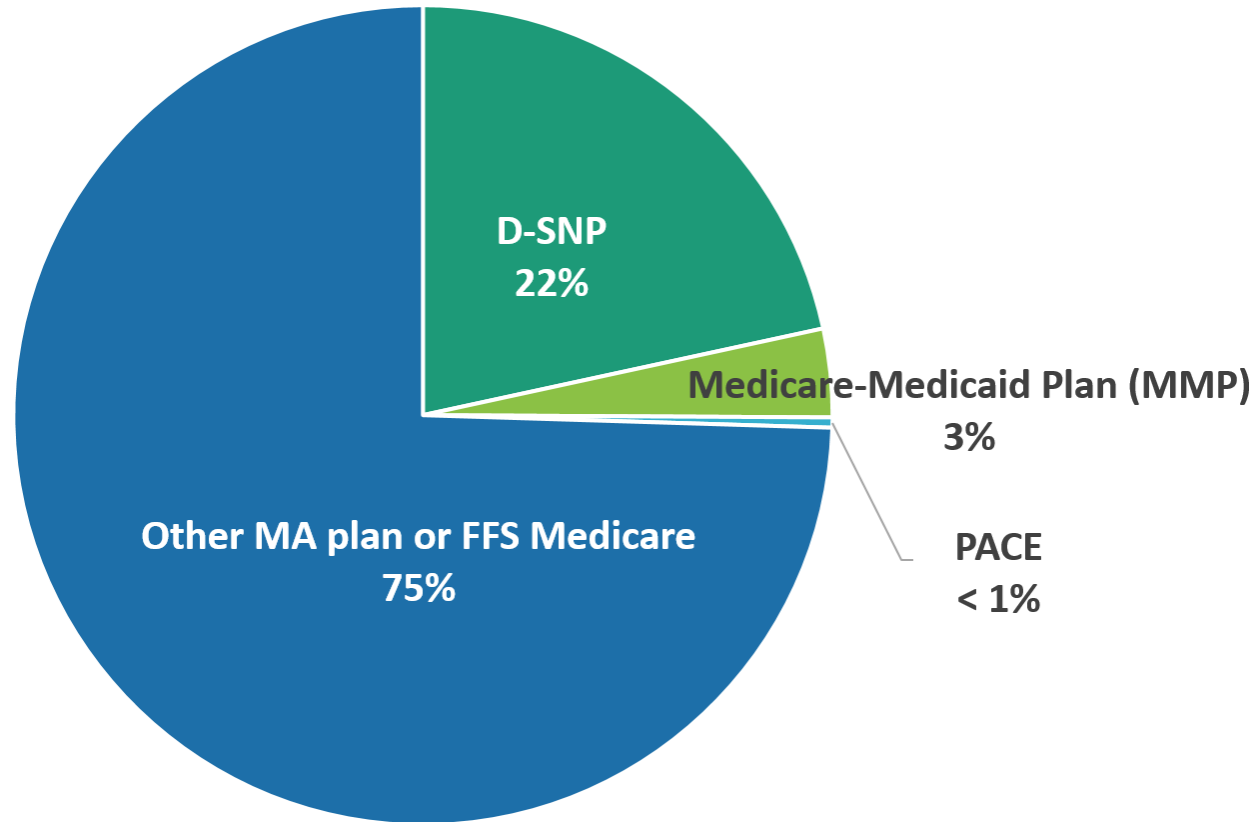
For some ways in which states can use MOCs, see ICRC tip sheet, “Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Integrating Medicaid Managed Long Term Services and Supports into D-SNP Models of Care” (June 2019): <https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-integrating-medicaid-managed-long>

D-SNP Enrollment Among All Medicare Beneficiaries



Source: Kaiser Family Foundation. "A Dozen Facts About Medicare Advantage in 2019." June 2019. Available at: <http://files.kff.org/attachment/Data-Note-A-Dozen-Facts-About-Medicare-Advantage-in-2019>

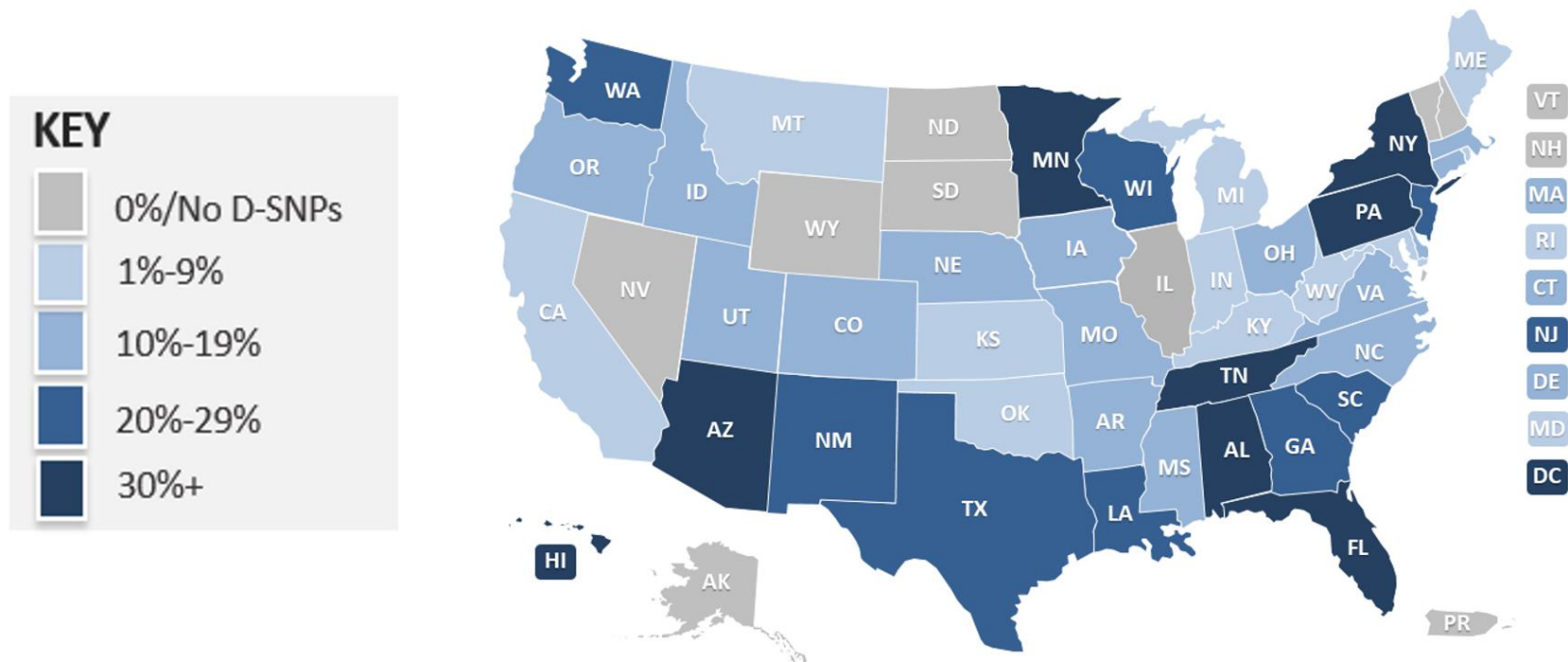
D-SNP Enrollment Among All Dually Eligible Beneficiaries, September 2018



Note: PACE programs may enroll non-dually eligible individuals in some states. PACE Enrollment in September 2018 was 43,303 – less than 1% of the total number of dually eligible enrollees in that month.

Sources: CMS Quarterly Enrollment Snapshot, September 2018. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html>; CMS Monthly Enrollment by Contract Report, September 2018. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/Monthly-Enrollment-by-Contract.html>; and CMS Special Needs Plan Comprehensive Report, September 2018. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html>

Percentage of All Dually Eligible Beneficiaries Served by D-SNPs, Jan 2019



Notes: Five plans spanned multiple states. For this map, enrollment in those five plans was divided equally among states served. Some states allow partial benefit duals in D-SNPs, which are also captured in this map. Total D-SNP enrollment reflects January 2019 data, while the total number of dually eligible beneficiaries reflects December 2017 data, per the sources below. Data for Puerto Rico (PR) are not included in the monthly enrollment snapshot, so PR enrollment data is not reflected in this map.

Sources: CMS. *SNP Comprehensive Report*. January 2019. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2019-1.html?DLPage=2&DLEntries=10&DLSort=1&DLSortDir=descending>; and CMS. *CMS Monthly Enrollment Snapshots*, December 2017. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources.html>.

Basics of D-SNP Contracting

D-SNP Contracts

- D-SNPs have two, 2-way contracts
 - One contract with the Centers for Medicare & Medicaid Services (CMS)
 - One contract with the state Medicaid agency,¹ in which, at a minimum:
 - D-SNP agrees to “provide Medicaid benefits, or arrange for benefits to be provided”
 - State Medicaid agency agrees to allow the D-SNP to serve and coordinate care for dually eligible beneficiaries

States are not required to contract with D-SNPs generally or with particular MA organizations. States have the authority to deny contracts to potential D-SNPs.

1. State Medicaid agency contracts with D-SNPs are often referred to as “SMACs” or “MIPPA contracts.”

Benefit Integration

- States can require D-SNPs to cover any or all Medicaid benefits, including:
 - Medicare beneficiary cost sharing for Qualified Medicare Beneficiaries (QMBs) and Full Benefit Dually Eligible Beneficiaries (FBDEs)
 - Drugs excluded from coverage by Medicare Part D
 - Medicaid services that overlap with Medicare (for example, home health and durable medical equipment)
 - Behavioral health (BH) services
 - Long-term services and supports (custodial nursing facility care, home- and community-based services (HCBS))
 - Services that may be provided through Medicaid, but are not covered by Medicare, such as transportation, vision, dental, or hearing benefits

What States New to D-SNP Contracting Need to Know

- D-SNPs enter and leave states based on the Medicare contracting schedule; may not be the same as the state Medicaid contracting schedule
 - ICRC calendar of “Key Medicare Advantage Dates and Action Items for States Contracting with D-SNPs” (September 2017):
https://www.integratedcareresourcecenter.com/PDFs/Key_MA_Dates_for_States_Contracting_with_D-SNPs.pdf
- Medicare has detailed processes to ensure network adequacy, provide oversight, and monitor quality that apply to D-SNPs and other MA plans
- State contracts with D-SNP must include minimum contract elements, but states may include additional requirements to improve administrative, clinical, and financial integration for enrollees

MA Contract Oversight and Network Adequacy

- CMS has detailed procedures for overseeing and monitoring all MA contracts, including D-SNP contracts
 - Discussed in a call with CMS and states in May 2014, hosted by ICRC and NAMD, and summarized here: <http://www.chcs.org/media/ICRC-D-SNP-Contract-Oversight-and-Quality-Monitoring-Summary-May-2014.pdf>
- MA networks are reviewed at the contract level, rather than the plan level
 - A contract may include more than one plan and plan type, and may cover multiple states
 - CMS considers: (1) number of providers by type; and (2) travel time and distance to providers and facilities
 - Summary of a January 2014 network adequacy discussion between CMS and states: <http://www.chcs.org/media/ICRC - D-SNPs and MA Network Adequacy - Discussion Summary 2-27-14.pdf>
 - Full CMS Network Adequacy Guidance for D-SNPs (and other MA plans), February 2018: <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/2018-Network-Adequacy-Guidance.pdf>

Current Minimum Contract Elements – D-SNP contracts with states must include:

“(1) The MA organization's responsibility to — (i) **Coordinate the delivery of Medicaid benefits** for individuals who are eligible for such services; and (ii) **If applicable, provide coverage of Medicaid services**, including long-term services and supports and behavioral health services, for individuals eligible for such services.

(2) The **category(ies) and criteria for eligibility** for dual eligible individuals to be enrolled under the SNP, including as described in sections 1902(a), 1902(f), 1902(p), and 1905 of the Act.

(3) The **Medicaid benefits** covered under a capitated contract between the State Medicaid agency and the MA organization offering the SNP, the SNP's parent organization, or another entity that is owned and controlled by the SNP's parent organization.

...

Source: 42 CFR §422.107(c), as amended by the Final Rule entitled “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,” published at 84 FR 15828.

Current Minimum MIPPA Elements – D-SNP contracts with states must include:

...

- (4) The **cost-sharing protections** covered under the SNP.
- (5) The identification and sharing of information on Medicaid **provider participation**.
- (6) The **verification of enrollee's eligibility** for both Medicare and Medicaid.
- (7) The **service area** covered by the SNP.
- (8) The **contract period** for the SNP.”

Source: 42 CFR §422.107(c), as amended by the Final Rule entitled “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,” published at 84 FR 15828.

NEW Minimum Contract Elements – 2021

- For D-SNPs that are “applicable integrated plans,” as defined in 42 CFR §422.561, a requirement for the use of new unified appeals and grievance procedures
- For D-SNPs that are not “fully integrated” or “highly integrated” D-SNPs, a stipulation that the D-SNP notifies, or arranges for another entity/entities to notify, the state Medicaid agency or a designee, of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dually eligible beneficiaries

(Both of these new requirements will be discussed later in the presentation.)

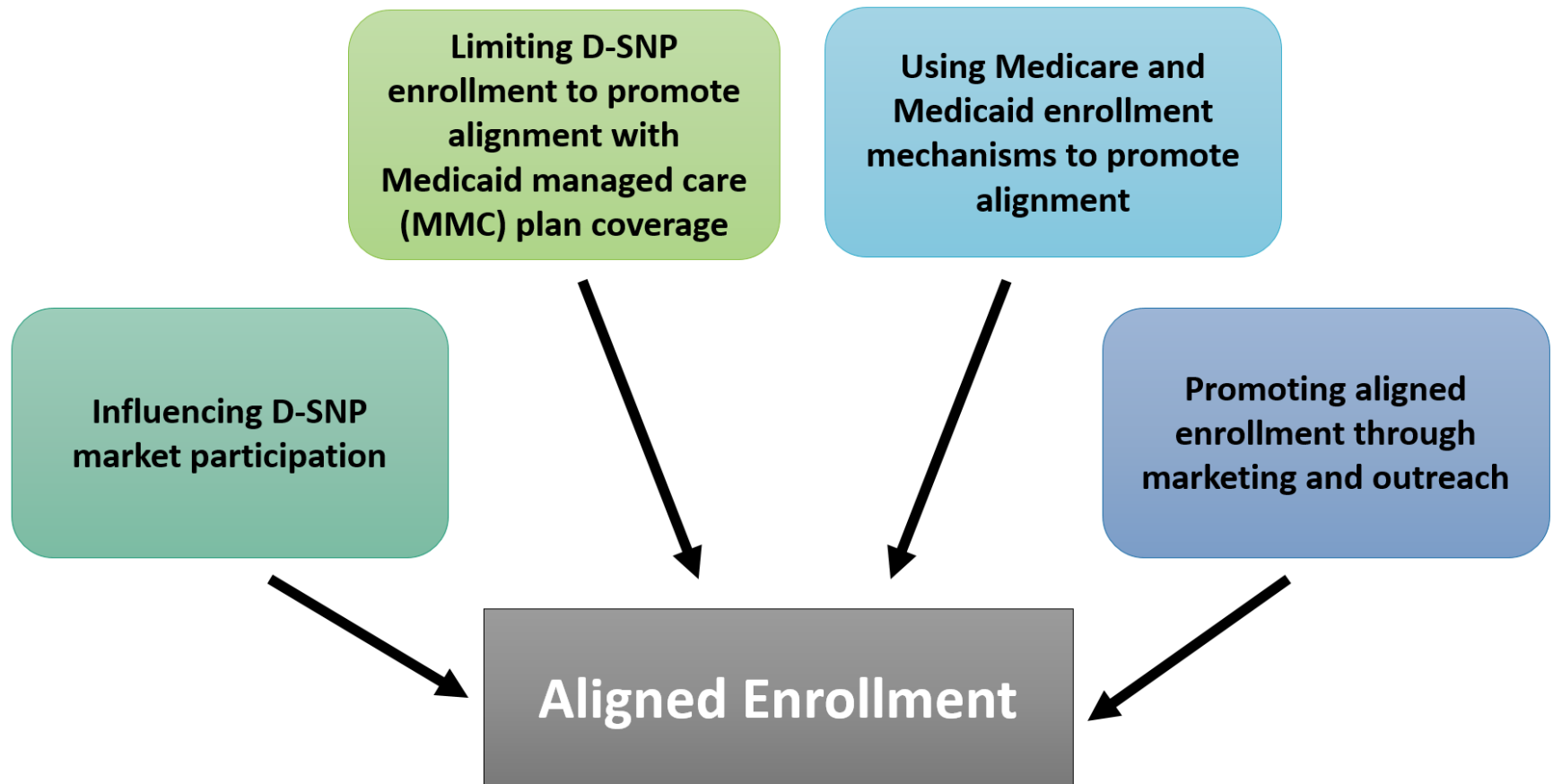
Beneficiary Cost-Sharing Protections

- All MA organizations – not just D-SNPs – must educate providers about federal statutory prohibition against balance billing of QMBs
 - MA contracts with providers must specify that providers will accept MA payment as payment in full or bill Medicaid for Medicare cost sharing²
 - Information about prohibition on improper billing of QMBs:
<https://www.cms.gov/medicare-medicare-coordination/medicare-and-medicare-coordination/medicare-medicare-coordination-office/qmb.html>
- ICRC TA brief, “Preventing Improper Billing of Medicare-Medicaid Enrollees in Managed Care: Strategies for States and Dual Eligible Special Needs Plans” (July 2017):
 - https://www.integratedcareresourcecenter.com/PDFs/ICRC_Prevent_Improper_Billing.pdf

Using Aligned Enrollment to Achieve Integration Goals

- **Aligned enrollment:** When a full-benefit D-SNP enrollee receives coverage of Medicaid benefits from the D-SNP or from a Medicaid managed care organization (MCO) that is:
 - Offered by the D-SNP organization;
 - Offered by the same parent organization as the D-SNP; or
 - Offered by another entity that is owned and controlled by the D-SNP's parent organization.
- **“Affiliated” plans:** D-SNPs and Medicaid MCOs managed by the same parent organization/entity
 - Sometimes referred to as “companion” plans
- **Exclusively aligned enrollment:** When the state Medicaid agency limits D-SNP membership to individuals enrolled in the D-SNP's affiliated Medicaid MCO.
- ICRC tip sheet, “Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment” (April 2018):
<https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-promoting-aligned-enrollment>

State Contracting and Policy Approaches That Promote Aligned Enrollment



Influencing D-SNP Market Participation

- **Require contracted Medicaid MCOs that serve dually eligible beneficiaries to offer affiliated D-SNPs in the same service area**
 - State examples:¹ Arizona, Hawaii, Idaho, Massachusetts, Minnesota, Pennsylvania, Tennessee, Texas, and Virginia
- **Only contract with D-SNPs whose parent organizations have Medicaid managed care contracts with the state**
 - State examples:² Arizona, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, Tennessee, Virginia

¹ New Mexico requires Medicaid managed care plans to offer D-SNPs, but not in the same service area, so they are not included in this list. Idaho contracts with two FIDE SNPs to cover all Medicaid benefits for enrolled dually eligible beneficiaries. In Massachusetts, Senior Care Options (SCO) program plans that serve dually eligible beneficiaries are required to offer affiliated D-SNPs. Texas requires Medicaid MCOs in certain counties to offer D-SNPs in the same service area. Virginia Medicaid managed care plans are required to offer a D-SNP within 3 years of Medicaid contract award.

² D-SNPs contracted with the state of Tennessee before January 2014 are exempt from this requirement.

Limiting D-SNP Enrollment to Promote Alignment with MMC Coverage

- **Limit D-SNP enrollment to full-benefit dually eligible (FBDE) beneficiaries (or require use of separate benefit packages for FBDEs and partial-benefit dually eligible beneficiaries) to allow delivery of a uniform Medicare-Medicaid benefit package**
 - State examples: Arizona, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, New York,¹ Pennsylvania,² Virginia, Wisconsin¹
- **Limit D-SNP enrollment to individuals enrolled in affiliated Medicaid managed care plans**
 - State examples: Idaho, Massachusetts, Minnesota, New Jersey

¹ New York and Wisconsin restrict enrollment in their integrated FIDE SNPs to FBDEs, but both states also allow operation of other D-SNPs (which are not part of the states' integrated care programs); those additional D-SNPs may be allowed to enroll partial benefit dually eligible beneficiaries.

² Only FBDEs are eligible for Pennsylvania's Community Health Choices (CHC) program, so the state requires D-SNPs affiliated with CHC MCOs to only enroll FBDEs. If those D-SNPs want to enroll partial-benefit dually eligible beneficiaries, they must do so under a separate plan benefit package.

Using Medicare and Medicaid Enrollment Mechanisms to Promote Alignment

- Use automatic assignment to enroll beneficiaries into affiliated Medicaid MCOs
 - State examples: New Jersey, Minnesota, Idaho
- Allow (or require) D-SNPs to seek approval for default enrollment of Medicaid managed care members when they become Medicare-eligible
 - State examples: Arizona, Oregon, Tennessee, Pennsylvania
- Use passive enrollment to maintain aligned enrollment with Medicaid managed care re-procurements or D-SNP non-renewals
- Resources on default and passive enrollment:
 - ICRC fact sheet, “Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Beneficiaries” (updated May 2019): <https://www.integratedcareresourcecenter.com/resource/using-default-enrollment-align-coverage-dually-eligible-medicare-medicad-beneficiaries>
 - ICRC webinar, “Aligning Coverage for Dually Eligible Beneficiaries Using Default and Passive Enrollment” (July 2018): <https://www.integratedcareresourcecenter.com/webinar/aligning-coverage-dually-eligible-beneficiaries-using-default-and-passive-enrollment>

Promoting Aligned Enrollment through Marketing and Outreach

- Encourage or require D-SNPs to target marketing only to enrollees in their affiliated Medicaid managed care plans
 - State examples: Arizona, Virginia
- Conduct outreach (for example, via letters, phone calls) to dually eligible enrollees regarding the benefits of aligned enrollment and steps to enroll in affiliated plans
 - State examples: Arizona
- Engage and train state enrollment counseling/enrollment broker staff and/or other benefits counselors (State Health Insurance Assistance Program (SHIP) volunteers, Aging and Disability Resource Centers (ADRCs), etc.) to ensure they understand integrated options and can explain them clearly to beneficiaries
 - State examples: Arizona

ICRC TA Tool on D-SNP Contracting

ICRC's November 2016 TA tool *State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options* provides an in-depth analysis of D-SNP contracts in 13 states (AZ, FL, HI, ID, MA, MN, NJ, NM, OR, PA, TN, TX, and WI)

https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues_Options.pdf

New Integration Requirements for D-SNPs

Bipartisan Budget Act of 2018

- The Act includes several provisions that impact D-SNPs and Medicare-Medicaid alignment
 - Permanently authorizes MA SNPs, including D-SNPs, Chronic Condition SNPs (C-SNPs), and Institutional SNPs (I-SNPs)
 - Requires increased integration of D-SNP benefits and appeals and grievance processes
 - Requires that CMS establish new minimum integration standards
 - Designates MMCO as the dedicated state point of contact on D-SNP integration misalignments

New Integration Criteria for D-SNPs

- D-SNPs must meet at least one of the following criteria effective CY 2021
 - 1) Cover Medicaid behavioral health services and/or LTSS to be either:
 - A Fully Integrated Dual Eligible SNP, or
 - A Highly Integrated Dual Eligible SNP
 - 2) Notify state and/or its designee(s) of Medicare hospital and skilled nursing facility (SNF) admissions for group of high-risk enrollees to improve coordination during transitions of care
- States will need to work with D-SNPs on new contract provisions ahead of the July 1, 2020 submission deadline

Source: CMS. "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." *Federal Register*, April 16, 2019, pp.15710-15718 and 42 CFR 422.107(d)) p. 15828. Available at: <https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf>

Fully Integrated Dual Eligible SNPs (FIDE SNPs)

- Provide Medicare and Medicaid benefits under a single entity.
- Provide coverage, consistent with state policy of Medicaid benefits, including long-term services and supports.
 - Must cover at least 180 days of nursing facility services per plan year
- Promote alignment through:
 - Integrated Medicare and Medicaid care management model, and
 - D-SNP policies and procedures that coordinate or integrate enrollment, member materials, communications, grievance and appeals and quality improvement.
- May be eligible for the frailty factor payment adjustment if their risk scores indicate a “similar average level of frailty” as the PACE program
 - For details see CMS April 2016 Call Letter, pp. 60, at this link:
<https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf>

Source: 42 CFR §422.2, as amended by the Final Rule entitled “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,” published at 84 FR 15827.

Highly Integrated Dual Eligible SNPs (HIDE SNPs)

- Provides coverage, consistent with state policy, of:
 - LTSS; **and/or**
 - Behavioral health services
- Provides LTSS and/or BH services under a capitated contract between the Medicaid agency and:
 - The MA organization; **or**
 - The MA organization's parent organization; **or**
 - Another entity owned and controlled by the MA organization's parent organization.

Source: 42 CFR §422.2, as amended by the Final Rule entitled "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," published at 84 FR 15827.

FIDE SNP vs HIDE SNP Comparison

Feature	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 Social Security Act.	Yes	No
May provide coverage of Medicaid services via a PIHP or a 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
Must have a capitated contract with the state Medicaid agency to provide coverage of long-term services and supports (LTSS), consistent with state policy	Yes	No
Must have a capitated contract with the state Medicaid agency to provide coverage of behavioral health services, consistent with state policy.	No	No
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

Source: 42 CFR §422.2, as amended by the Final Rule entitled “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,” published at 84 FR 15707 and 15827.

Hospital and SNF Admission Notification Requirement

- **Goal:** Improve coordination of Medicare and Medicaid services between settings of care for at least one group of high-risk full-benefit dual eligible individuals
 - D-SNPs (or a designated entity) must notify the state (and/or individuals/entities designated by the state)
 - State determines:
 - Who is “high risk”
 - Who will be notified
 - The timeframe for the notification
 - The notification method
- Requirement does not apply if D-SNP is a HIDE or FIDE SNP

Source: 42 CFR §422.107(d), as amended by the Final Rule entitled “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,” published at 84 FR 15828.

Approaches to Information Sharing

- **Potential populations.** States have broad flexibility to define a target population, including all D-SNP enrollees or a targeted subset, such as:
 - Home- and community-based services waiver participants
 - Medicaid health home program participants
 - Another group defined through the state Medicaid agency's use of claims or encounter data to target high utilizers of acute care or other services
- In identifying a high-risk population states should consider whether care management infrastructure is available to respond to the notifications
- **Potential mechanisms.** States determine the notification method, entities to be notified, and process that will be used, including use of existing systems and/or Health Information Exchanges (HIEs), such as:
 - D-SNP-to-state designee (i.e., via daily reports to Medicaid MCO or FFS care manager)
 - D-SNP receives information from an event notification system or gathers it from an HIE platform

State Information Sharing Examples

Parameter	Tennessee	Pennsylvania	Oregon
Target D-SNP Population	D-SNP FBDE enrollees, in both affiliated and unaffiliated D-SNPs	D-SNP enrollees, in both affiliated and unaffiliated D-SNPs	FBDE enrollees, in both affiliated and unaffiliated D-SNPs, including FFS LTSS beneficiaries
Entity Notified	TennCare MCO	Community Health Choices-MCO service coordination staff	Medicaid MCO or state care management (CM) staff and providers, including FFS LTSS CMs
Timeframe for Notification	Within 2 business day of the “anchor date” ¹	Within 48 hours of specified events	Timely
Notification Mechanism	Daily reports via state-developed portal	D-SNP to Medicaid MCOs/MLTSS plans	Event notification system

¹ TennCare defines the anchor date as, “The date of receipt of notification by the Contractor of upcoming (i.e., planned) or current inpatient admissions and current or recently completed observation days or emergency department visits. The anchor date is not included in the calculation of days within which the Contractor is required to take action.”

Unified Grievances and Appeals (G&A)

- Coordinated G&A process for all D-SNPs for CY2020
- Unified G&A process for exclusively aligned D-SNPs (FIDE and HIDE SNPs) for CY2021

All D-SNPs (2020)

Must offer to assist with obtaining Medicaid services, resolving grievances, requesting authorization of services, and navigating G&A

Must provide enrollee reasonable assistance in completing G&A forms and taking procedural steps

May coach the enrollee on how to self-advocate

FIDE/HIDE with Exclusively Aligned Enrollment (2021)

Integrated organization determinations (Medicare determinations and adverse benefit determinations)

Integrated reconsiderations (MA reconsideration/ appeal of adverse org determination)

Integrated grievance (dispute or complaint about providers)

Unified Grievances and Appeals

- HIDE SNPs and FIDE SNPs **with exclusively aligned enrollment** must implement unified Medicare and Medicaid appeals and grievances process in 2021.
 - *For each dual eligible special needs plan that is an applicable integrated plan as defined in 42 CFR §422.561, a requirement for the use of the unified appeals and grievance procedures under §§422.629 through 422.634, 438.210, 438.400, and 438.402.*
- Intended to provide enrollees a simpler, more straightforward grievance and appeals process.
- Unified plan-level process would include:
 - One timeline for resolution of grievances.
 - One unified process for appeals.
- The final rule does not make changes to the post-plan appeals process (i.e., state fair hearings and Medicare appeals).

Source: 42 CFR §422.107(c), as amended by the Final Rule entitled “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,” published at 84 FR 15828.

Implementation

- Important Medicare Advantage (MA) deadlines
 - **November 2019:** Notice of intent to apply (NOIA) from D-SNP applicants due to CMS for CY 2021
 - **June 2020:** MA organizations submit bid and plan benefit package for the upcoming year
 - **July 1, 2020:** MA organizations submit signed state Medicaid agency D-SNP contracts to CMS
 - **January 1, 2021:** New integration standards must be in place

Some Key Medicare Terms

- **State Medicaid Agency Contract (SMAC) or MIPPA Contract** – Interchangeable terms for required state contracts that D-SNP applicants must submit to CMS by July 1st of each year to receive approval from CMS to operate a D-SNP product in a state in the upcoming year.
- **Notice of Intent to Apply (NOIA)** – CMS requires notification from all interested plans in November of each year for all new contracts, contract extensions, or service area expansions planned for the next full MA plan cycle (e.g., Nov 2017 NOIAs are for the CY 2019 plan cycle).
- **Call Letter** – Medicare Advantage guidance document that accompanies advance notice and announcement of Medicare Advantage capitated rates; issued each year by CMS in draft form in February and final form in April.
- **Medicare Bid and Plan Benefit Package** – Two main components of Medicare Advantage plan applications that describe the plan's premiums, coverage details, and cost-sharing for all covered benefits, and that may be tailored to align with integrated D-SNP program requirements. Must be submitted to CMS by the first Monday in June for the upcoming year.
- **Medicare Star Ratings** – The CMS five-star quality and performance rating system applicable to all Medicare Advantage and Prescription Drug Plans. Issued in October of each year for the upcoming year.
- **Low Income Subsidy (LIS) Medicare Part D Reassignment** – Annual movement of Medicare beneficiaries from their current Medicare Prescription Drug Plan (PDP) or terminating Medicare Advantage Prescription Drug Plan (MA-PD) to another PDP if necessary to maintain the option of minimum beneficiary cost-sharing.

D-SNP Contracting Resources

- [Key Medicare Advantage Dates and Action Items for States Contracting with Dual Eligible Special Needs Plans](http://www.integratedcareresourcecenter.com/PDFs/Key_MA_Dates_for_States_Contracting_with_D-SNPs.pdf) (ICRC/September 2017) Describes program milestones by month and explains what activities state Medicaid agencies may want to undertake to prepare for or respond to a particular Medicare Advantage event.
http://www.integratedcareresourcecenter.com/PDFs/Key_MA_Dates_for_States_Contracting_with_D-SNPs.pdf
- [Medicare Advantage D-SNP Non-Renewals, Service Area Changes, Terminations, and New Entries: CMS Requirements and State Options](http://www.integratedcareresourcecenter.com/PDFs/ICRC_D-SNP_Entries_and_Departures_September_2017.pdf) (ICRC/September 2017) Outlines CMS' requirements and state contracting options under a variety of situations affecting D-SNPs. http://www.integratedcareresourcecenter.com/PDFs/ICRC_D-SNP_Entries_and_Departures_September_2017.pdf
- [Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees](https://www.integratedcareresourcecenter.com/content/medicare-basics-overview-states-seeking-integrate-care-medicare-medicaid-enrollees) (ICRC/June 2017) Helps states better structure and coordinate the Medicaid benefits they offer to Medicare-Medicaid enrollees by providing them with basic information on the Medicare program, the services it covers, and the process used to set rates.
<https://www.integratedcareresourcecenter.com/content/medicare-basics-overview-states-seeking-integrate-care-medicare-medicaid-enrollees>
- [State and Health Plan Strategies to Grow Enrollment in Integrated Managed Care Plans for Dually Eligible Beneficiaries](http://www.integratedcareresourcecenter.com/PDFs/ICRC_Growing_Enrollment_in_Integrated_Managed_Care_Plans_FINAL_6-01-17.pdf) (ICRC/June 2017) Outlines a variety of actions that states and health plans can take to support enrollment growth in integrated care programs.
http://www.integratedcareresourcecenter.com/PDFs/ICRC_Growing_Enrollment_in_Integrated_Managed_Care_Plans_FINAL_6-01-17.pdf
- [State Contracting with Medicare Advantage Dual Eligible Special Needs Plans \(D-SNPs\): Issues and Options](http://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues_Options.pdf) (ICRC Brief/November 2016) Analyzes the D-SNP contracts in 13 states, providing guidance and examples for states that are interested in beginning or expanding D-SNP contracting efforts. http://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues_Options.pdf
- [Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Beneficiaries](https://www.integratedcareresourcecenter.com/resource/using-default-enrollment-align-coverage-dually-eligible-medicare-medicaid-beneficiaries) (May 2019) Summarizes default enrollment requirements and state roles in the default enrollment approval and implementation process.
<https://www.integratedcareresourcecenter.com/resource/using-default-enrollment-align-coverage-dually-eligible-medicare-medicaid-beneficiaries>

D-SNP Contracting Resources (Cont.)

- [State Medicaid Managed Long-Term Services and Supports Programs: Considerations for Contracting with Medicare Advantage Dual Eligible Special Needs Plans](https://www.chcs.org/resource/state-medicaid-managed-long-term-services-supports-programs-considerations-contracting-medicare-advantage-dual-eligible-special-needs-plans/) (Center for Health Care Strategies/November 2016) Explores state considerations for requiring D-SNPs to become Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) and examines the varying levels of alignment possible through D-SNP contracting. <https://www.chcs.org/resource/state-medicaid-managed-long-term-services-supports-programs-considerations-contracting-medicare-advantage-dual-eligible-special-needs-plans/>
- [D-SNP Performance Monitoring and Oversight: State Experiences and CMS Resources](https://www.integratedcareresourcecenter.com/webinar/d-snp-performance-monitoring-and-oversight-state-experiences-and-cms-resources) (April 2019) Covers resources and strategies available to states to begin or improve their oversight of D-SNPs. <https://www.integratedcareresourcecenter.com/webinar/d-snp-performance-monitoring-and-oversight-state-experiences-and-cms-resources>
- [How States Can Use Medicare Advantage Star Ratings to Assess D-SNP Quality and Performance](https://www.integratedcareresourcecenter.com/sites/default/files/CMS_MA_Star_Ratings_2019.pdf) (October 2018) Answers basic questions about star ratings and how states can use these measures for D-SNP oversight. https://www.integratedcareresourcecenter.com/sites/default/files/CMS_MA_Star_Ratings_2019.pdf
- Tips to Improve Medicare-Medicaid Integration Using D-SNPs:
 - [Integrating Medicaid Managed Long-Term Services and Supports into D-SNP Models of Care](https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-integrating-medicaid-managed-long-term-services-supports-into-d-snp-models-of-care) (June 2019) Outlines the benefits of integrated MOCs, lists the steps in developing and implementing an integrated MOC, and provides examples of state-specific elements that Massachusetts and Minnesota require D-SNPs to include in their MOCs. <https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-integrating-medicaid-managed-long-term-services-supports-into-d-snp-models-of-care>
 - [Using Medicare Program Audit Reports to Improve Managed Care Organization Oversight](https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_TipSheet_Using_Audit_Reports_June_2018.pdf) (June 2018) Describes how states can use the results of Medicare program audits to identify performance issues impacting dually eligible beneficiaries' receipt of care coordination, long-term services and supports, durable medical equipment, and other services, and incorporate that information into their audit and oversight activities. https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_TipSheet_Using_Audit_Reports_June_2018.pdf
 - [Designing an Integrated Summary of Benefits Document](https://www.integratedcareresourcecenter.com/PDFs/DSNP_SB_Tip_Sheet.pdf) (June 2018) Describes how states can start to improve member materials by using contractual requirements to ensure that Medicare and Medicaid benefit information for aligned plans is incorporated into a single, streamlined Summary of Benefits document. https://www.integratedcareresourcecenter.com/PDFs/DSNP_SB_Tip_Sheet.pdf
 - [Promoting Aligned Enrollment](https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-promoting-aligned-enrollment) (April 2018) Outlines tips for promoting aligned enrollment in states looking to integrate care for dually eligible beneficiaries using contracting strategies that maximize the opportunity for D-SNPs and Medicaid managed care plans. <https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-promoting-aligned-enrollment>

About ICRC

- Established by CMS to advance integrated care models for dually eligible beneficiaries
- ICRC provides technical assistance (TA) to states, coordinated by Mathematica Policy Research and the Center for Health Care Strategies
- Visit <http://www.integratedcareresourcecenter.com> to submit a TA request and/or download resources, including briefs and practical tools to help address implementation, design, and policy challenges
- Send other ICRC questions to: integratedcareresourcecenter@chcs.org