



July 11, 2011

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Centers for Medicare & Medicaid Services  
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Mr. Berwick:

On behalf of **Medicaid Health Plans of America (MHPA)**, I am pleased to submit the following comments in response to the May 16, 2011 Request for Information regarding the **Opportunities for Alignment Under Medicaid and Medicare**.

MHPA is a national nonprofit organization and the leading trade association solely focused on representing Medicaid health plans. MHPA's 27 member plans range from large multi-state plans to small community-based plans and partner with 35 states for the delivery of Medicaid benefits and services. MHPA's mission is to develop and advance public policy that controls costs and improves access and delivery of quality health care to Medicaid members.

MHPA applauds CMS for undertaking the Alignment Initiative to better integrate the provision of health benefits to those "dually eligible" beneficiaries covered under Medicaid and Medicare. We note that the majority of the nation's 8.9 million dual eligible beneficiaries do not currently access their health benefits via an integrated care model. Therefore, most dual eligibles are forced to navigate between multiple programs to obtain health care services. A patient may see a physician through Medicare, receive home and community-based support services through Medicaid, and obtain prescription drugs through a Part D plan. The lack of communication between providers, unmanaged episodes of care, and the subsequent higher utilization, are major contributors to the high cost and poor health outcomes for the dual eligible population.<sup>1</sup> This situation presents serious cost, quality, and access challenges for policymakers.

MHPA encourages CMS to use the integrated Dual Eligible Special Needs Plans (D-SNP) permitted under Medicare Advantage as a model for the Alignment Initiative. An integrated model of coordinated care will generate program savings through administrative simplification that can be passed on to the Federal government and states to reduce their Medicare and Medicaid expenditures. Furthermore, we encourage CMS to rely upon lessons learned and best practices gleaned from the Medicaid health plans participating in this program to guide future integration strategies. Medicaid health plans have unique experience in providing coordinated care to dual eligibles necessary to facilitate seamless care, improve health outcomes, and achieve cost savings. We recognize that effective care coordination for this population involves

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<sup>1</sup> Supporting Integrated Care for Dual Eligibles. Center for Health Care Strategies. July 2009.

developing comprehensive provider networks, preventing hospitalizations, nursing home diversion through home and community-based services, coordinating care transitions (home to community to nursing to acute, etc.), the alignment of social, medical, and behavioral services, individual care plan development, and community-based outreach, all supported by robust data sharing in information systems.

To this end, MHPA submits the following comments for consideration:

### **Coordinated Care - Enrollment**

Of the 1.5 million dual eligible beneficiaries in Medicare Advantage and Special Needs Plans (SNP), only 120,000 are in programs that fully integrate Medicare and Medicaid services.<sup>2</sup> This low enrollment is unfortunate because integrated managed care can offer huge benefits for dual eligible beneficiaries, such as negligible or no cost sharing and generous benefits compared with a fee-for-service environment. There are several factors contributing to low enrollment, including: 1) the burdensome eligibility and enrollment processes required for the two programs which can be frustrating for beneficiaries to navigate; 2) the bifurcation of Medicare and Medicaid program requirements that makes it difficult for providers to successfully participate; and 3) bureaucratic red tape that makes it difficult for health plans to pursue integrated models. Many of these topics are addressed in other parts of our response. Here, MHPA has several suggestions for facilitating the enrollment of more individuals into integrated care models.

First, MHPA encourages CMS to work with Congress to eliminate the Medicare and Medicaid restrictions that prohibit CMS and states from automatically enrolling the dual eligible population into integrated care arrangements. Medicare's requirement for voluntary enrollment into coordinated care plans is an obstacle to program growth, given the difficulty duals have in navigating the complex voluntary enrollment process. The Medicaid restrictions which require that states secure a Federal waiver to pursue mandatory managed care enrollment for this population is cumbersome. MHPA supports a policy that would permit CMS and the states to mandate dual eligible enrollment in managed care where possible. Alternatively, MHPA would support a policy clarification that requires states to automatically enroll duals in health plans, with preference given to enrolling them with health plans or providers with whom they have a historical relationship, and include an option to disenroll. However, in order to fully realize the care improvement and cost-saving potential of managed care, disenrollment should be disincentivized and limited to 60 days following initial assignment. After that period, beneficiaries should be locked in for a period of at least 12 months. This will permit health plans to most successfully apply care coordination and case management efforts to stabilize this complex and often transient population.

Second, MHPA recommends that health plans with integrated dual eligible products be permitted to offer meaningful, non-nominal incentives to encourage beneficiary participation in managed care as well as to reward desired behaviors (e.g., getting screening tests) once

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<sup>2</sup> Supporting Integrated Care for Dual Eligibles. *Center for Health Care Strategies*. July 2009.

members are enrolled. For example, to increase enrollment under an “opt-out” approach to participation in managed care, dual eligible beneficiaries electing a fee-for-service environment over managed care could be subject to higher cost-sharing. Once enrolled, a beneficiary’s successful participation in care management programs could be rewarded with incentives, such as gift cards for health related services. Similarly, dual eligible enrollees who comply with preventive service guidelines could receive pre-loaded debit cards or coupons to purchase health care-related items.

Third, in order to boost plan participation, health plans need a reasonable commitment from states that provides ample time to demonstrate improved outcomes and beneficiary experience, and which recognizes the upfront investment that plans make to enter a state market. Thus, states choosing to participate in integrated D-SNPs should be required to make a minimum three-year commitment. As cost savings are always a consideration for states, MHPA recommends that CMS consider incentives such as the opportunity for them to share equally with Medicare in any resulting cost savings.

### **Coordinated Care - Options**

In MHPA’s view, a tremendous benefit to requiring dual eligible beneficiaries to enroll with one managed care plan for all of their benefits would be the vast improvement in care coordination. MHPA recommends that, as a starting point, CMS require Medicaid agencies to provide one to two years of prior fee-for-service claims history to a health plan for each of its new enrollees. This will enable a health plan to know what services the individual has received, what diagnoses and conditions exist, what medications are being used, what providers are being utilized, etc. (without having to wait for several months for their own claims data to accumulate).

CMS could further facilitate this integration by streamlining the financing offered through each program. Currently, financing rules differ across Medicare and Medicaid, as well as within Medicare where there are different rules for fee-for-service Medicare beneficiaries versus D-SNP enrollees. This results in an extremely cumbersome and confusing system for providers, patients, plans and state Medicaid program administrators. To create a single financing stream, MHPA proposes two possible strategies that could improve care coordination. First, Medicare could provide an additional payment for coverage of additional Medicaid benefits for dual eligibles in the capitation rate. In turn, CMS could exclude the availability of FFP for coordination services for dual eligibles under the Medicaid program. The benefit to this approach would be that the provision and financing of care is seamless, and dual eligible beneficiary obtains all of the Medicaid covered benefits not covered by Medicare from one coordinated system of care.

As an alternative, MHPA suggests that Medicare could maintain its current benefits and payment structure. Medicaid regulations could be modified to require that states offer managed care plans and other models charged with coordination of benefits with an additional coordination benefit. To be truly effective, it would have to be consistent across state Medicaid programs, which could present serious administrative challenges for CMS.

Similarly, CMS could further facilitate integration by establishing clear guidelines and/or streamlining the benefits offered through each program. Currently, there are many benefits that are covered by both Medicare and Medicaid and the rules for how to coordinate these benefits are often vague. In the homecare arena, for example, coordination must occur “when the skilled episode ends,” but this lack of specificity leaves room for misinterpretation of the guideline. MHPA recommends that, at the very least, CMS establish greater clarity regarding coordination of benefits for dual eligibles. For example, for Skilled Nursing Facilities: Days 1-20 Medicare pays 100%; Days 21-100 Medicare pays 80% and Medicaid 20%; Days 100+, Medicaid pays 100%. To further streamline the benefits package, CMS should build upon the integrated D-SNP model by offering dual eligibles one standard package that will include all Medicare benefits, plus a standard “Medicaid enhancement” to include certain additional benefits commonly offered by Medicaid programs such as dental and vision coverage. This will increase the ease of plan participation, as well as reduce the administrative burden and costs on the state, CMS, and plans, who currently must engage in lengthy negotiations to agree to a common set of benefits and program requirements. In addition, it will create consistency across the country, making it easier for plans to operate in multiple states, to the benefit of dual eligibles, as plans with proven models are more able to replicate them.

#### **Coordinated Care - MA Cost Sharing Information in Standard Summary of Benefits**

In MHPA members’ experience, enrollees are often overwhelmed and confused by the multiple sets of materials explaining the benefits and cost sharing requirements associated with Medicare versus Medicaid coverage. As part of a coordinated model, MHPA recommends that CMS mandate that dually eligible beneficiaries be provided with one set of integrated materials explaining their combined Medicare/ Medicaid benefits and costs with one submission to either CMS or the State for final approval, but not both. Furthermore, MHPA recommends that CMS work with advocates and managed care plans to design these integrated materials over a two to three year period, leveraging market research and best practices from health care and other comparable industries. We recommend that CMS use the Medicare Advantage Summary of Benefits as a template within which Medicaid benefits could be included.

#### **Coordinated Care – Medicare Advantage Seamless Conversion**

MHPA understands that states are responsible for providing health plans with information about Medicaid recipients who become eligible for Medicare Advantage. States are not, however, providing this information in a timely manner to health plans, limiting their ability to utilize the seamless enrollment provisions described in the Medicare Managed Care Manual at 16B, section 50.8. MHPA members are finding that this time delay is extremely detrimental to the continuity of care for beneficiaries, especially for those who become eligible due to a disability since this determination is difficult for health plans to make themselves. MHPA recommends that CMS assume responsibility for providing health plans with timely data indicating which Medicaid plan members have become eligible for Medicare.

MHPA also recommends that when a Medicare Advantage member becomes dually eligible and the Medicaid plan in which they are enrolled has a D-SNP, that member be seamlessly enrolled into the same plan's D-SNP. This seamless conversion would provide a beneficiary with additional benefits and a more specialized product. This process should be similar to that used for Medicare Advantage members who become newly qualified for the Part D Low Income Subsidy. These beneficiaries are moved from the plan's Medicare Advantage product to the same plan's Medicare Advantage Prescription Drug (MA-PD) plan, if one is offered in the county. If one is not offered, only then is the member reassigned to another company's MA-PD plan. Furthermore, MHPA believes this seamless enrollment process should apply to existing dual eligible members enrolled in a Medicaid managed care plan who were not afforded the opportunity (or aware of the opportunity) to enroll in a D-SNP when they first aged into Medicare or became eligible by virtue of disability.

Enrollment should be facilitated with an annual process, which could include an opt-out, as currently outlined in the seamless conversion provision (found in the Medicare Managed Care Manual at 16B, section 50.8 and Chapter 2, section 40.1.4). Again, in order to fully realize the care improvement and cost-saving potential of managed care, we encourage CMS to limit the disenrollment grace period to 60 days following initial assignment. After that period, beneficiaries should be locked in for a period of 12 months. This will permit health plans to most successfully apply care coordination and case management efforts to stabilize this complex and often transient population.

### **Coordinated Care - Low Income Medicare Beneficiaries At Risk of Declining to Point of Qualifying for Medicaid**

MHPA is aware that the issue of spend down is a larger structural economic issue related more closely to financial security than the interface between Medicare and Medicaid. However, MHPA suggests that there are four strategies that Medicare could pursue to provide support to Medicare beneficiaries at risk of meeting the poverty and acuity criteria for Medicaid eligibility. These strategies, if implemented, could substantially impact the likelihood that a beneficiary would require institutional care.

MHPA encourages CMS to consider instituting the following strategies:

- 1) Offering a limited package of non-skilled home and community based services (assistance with ADL and IADLs) as part of the Medicare home health benefit. Expanded benefits in this arena could avert triggering Medicaid eligibility for Institutional Care and forestall nursing home placement. An example of a service to be included is the 10 post-acute meals that can currently be offered under Medicare Advantage;
- 2) Creating additional focus and/or benefits directed toward wellness programs specifically designed for frail individuals;
- 3) Encouraging enrollment in Medicare plans that employ specific interventions designed to improve chronic care; and/or

- 4) Directing enrollment into plans that employ enhanced care transitioning and community based post-acute care.

### **Coordinated Care – SNP Current Contracting Issues/Future Contracting Issues**

In their two decades of work with state Medicaid programs, MHPA members have found that there are few state policymakers who possess a detailed understanding of Medicare regulations. This knowledge gap has made effective implementation of Medicare/Medicaid integration contracts quite challenging. For example, implementation delays often occur as states attempt to make changes to and require approval of Medicare materials. This situation is exacerbated by inconsistencies in the information states receive from individual regional CMS contacts.

MHPA recommends that CMS create a training program or Medicare primer to deliver to the states and its regional offices covering the fundamentals of D-SNP contracting and the role of states in the review and approval of Medicare materials for duals. Health plans are currently experiencing wide variation in negotiating with states and CMS regional offices, even with the availability of some templates, in interpreting Medicare regulations as they apply to dual eligibles. Furthermore, MHPA recommends that CMS provide contract guidelines to states that would include: MIPAA required language, contract term requirements, categories of duals and what the requirements are for those categories, Medicaid indicator file requirements, and types of contracts allowed, i.e. coordination of benefits (should CMS elect not to pursue an integrated model of care for dual eligibles), cost-sharing, integrated, or fully-integrated.

### **Coordinated Care – Managed Care SNP Enrollment Requirements**

MHPA recommends CMS simplify the eligibility and enrollment process for dual eligibles, which currently requires beneficiaries to navigate two separate processes. With respect to eligibility determinations, if states retain responsibility for this function, they should be required to share that information with CMS to facilitate beneficiary's enrollment into an integrated D-SNP. Preferably, CMS would institute a single standard point of determination for eligibility in the program to simplify enrollment for beneficiaries as well as enrollment brokers, reducing costs and maximizing program reach. We note that state Medicaid agencies currently have the authority to delegate certain Medicaid enrollment verifications to local offices. This places additional burden and complexity on Medicare Advantage plans to obtain the necessary evidence of eligibility as local offices are more likely to rely on manual, paper-based processes. This burden, in turn, can delay enrollment for the beneficiary and interrupt critical coordination of needed health care services for duals. Whether health plans receive enrollment information from local offices, states, or CMS, MHPA recommends that eligibility information is provided to health plans in a common, defined electronic format from a central office for their entire service area.

With respect to enrollment, MHPA recommends that CMS standardize the effective date of enrollment for dual eligibles. Medicare allows for the submission of enrollment applications to

occur up until the end of the month, with actual enrollment occurring the on the first of the following month. Medicaid submission must occur by the 20th of the month with actual enrollment on the first day or the second week of the following month depending on when they appear on the state roster. This presents a problem when trying to reconcile dual enrollment as many times eligibility timeframes do not coincide or Medicaid eligibility is deferred pending further review leaving the member enrolled in only one half of a dual program.

MHPA recommends that the process for redetermining eligibility be standardized across the states. It should occur once per year to limit churn. CMS should also establish a single retroactive eligibility redetermination standard that must be applied by all states to simplify the enrollment process.

### **Coordinated Care - SNP Marketing**

Currently, D-SNP enrollees must review two sets of materials to understand their health benefits coverage – one specific to Medicare and one specific to Medicaid. The format for these materials is governed by different sets of rules, regulators, and regulatory timelines (see Medicare Managed Care Manual Chapter 16-B Special Needs Plans, 70.1 and 70.2 and 42 CFR 438.104). For example, Medicare Advantage marketing materials are required to inform Medicare beneficiaries about traditional Medicare benefits and any additional benefits the health plan offers. The materials cannot explain the added benefits a dual eligible may receive as a participant in both Medicare and Medicaid (see Medicare Managed Care Manual: Publication 100-16, Chapter 3). As a result, the materials are inconsistent and often confusing for beneficiaries, so members do not understand how to access benefits. Providers also do not understand. As a result, these benefits go unused – or members pay for services out of their own pocket with dollars that might be better used for food or other necessities. The volume of materials is also expensive to produce and add to overall administrative costs for both programs.

MHPA recommends that CMS require that D-SNP enrollees receive only one set of materials which clearly explains their Medicare and Medicaid coverage and how they interact. MHPA also requests that CMS issue guidelines specific to the production of those materials, relying on the Medicare Advantage integrated D-SNP guidelines as the template. In addition to providing general guidance, MHPA encourages CMS to ensure that these guidelines include “model” documents for duals. Since Medicare is a national program, MHPA believes that it is more feasible to adopt the Medicare requirements as the basis for these guidelines. Medicaid best practices and content requirements should be incorporated and used to enhance the guidelines as appropriate.

The sales/ marketing outreach regulations are also vastly different in the two programs. Under Medicaid, in many states only community outreach approaches to marketing are allowed and commissioned sales are prohibited. However, under Medicare commissioned sales are permitted, which results in confusion and difficulty when deciding who is going to sell the dual

product, a Medicare or Medicaid representative. To manage the sales/marketing outreach regulations more effectively, MHPA recommends that CMS permit direct marketing to dual eligibles, which will provide health plans with the opportunity to educate them regarding the benefits of an integrated model and support beneficiaries ability to make informed decisions. With the 60 day opt out period after initial assignment (described earlier), beneficiaries will have the latitude to opt for a different delivery system should their original choice be incompatible with their preferences. In addition, MHPA supports dual eligible beneficiaries receiving the same protections that exist for other Medicare beneficiaries with respect to direct marketing.

### **Coordinated Care – SNP Quality Requirements**

Many states currently require data reporting *in addition to* the mandated CMS reports under the Medicare Advantage business line. These additional reports are unnecessarily burdensome to the health plans and distract from their ability to truly follow and impact standard measures to improve healthcare.

MHPA recommends that CMS establish a uniform set of quality requirements and metrics for the D-SNP, and require that plans report only on these standards. These requirements should satisfy both the Medicare and State Medicaid program requirements. The requirements should include the Medicare Advantage star ratings measures. Furthermore, CMS should require a single annual External Quality Review Organization (EQRO) review to help standardize the assessment of health plan performance across states. CMS should prohibit states from imposing additional requirements regarding quality performance (for example, there are a minimal number of children in the program on which to require metrics or PIPs) and treatment planning (D-SNP already requires care plans).

### **Coordinated Care – SNP Seamless Delivery of Services**

MHPA fully supports the use of integrated health plans for providing care to duals, and believes that it is the most effective model for ensuring the seamless delivery of health care services. As noted earlier, the subtleties in coverage differences between Medicare and Medicaid are confusing for dual eligibles and their providers. MHPA asserts that this confusion can be mitigated significantly if benefits are delivered by an integrated D-SNP Medicare Advantage health plan using Medicare Advantage communication materials. The health plan customer service and provider service units are able to educate members and providers on how the D-SNP Medicare Advantage model provides both the Medicare and Medicaid benefits as a comprehensive benefit package. Conversely, if a beneficiary is enrolled in two different health plans or fee-for-service for either Medicare or Medicaid, it is difficult for the beneficiary to easily obtain an explanation of how the programs integrate. MHPA believes that no other currently defined Medicare delivery model offers the same potential for truly seamless benefit delivery.

## **FFS Benefits – Behavioral Health**

MHPA finds that the behavioral health guidelines in Medicare and Medicaid are highly inconsistent. The Medicare guidelines found at 42 CFR 422.112 are vague, simply based on "medical necessity" or quality evaluations of network adequacy (see 42 CFR 422.152). However, the Medicaid guidelines found at 42 CFR 441 Subparts C and D are more specific, providing support only for services targeting substance abuse and severe psychiatric diagnoses. MHPA recommends that these guidelines be standardized for duals in order to streamline the programs, improve beneficiary understanding of their scope of benefits, and reduce plan and provider confusion. We believe coordinated behavioral health guidelines (as well as for other health care benefits) will significantly enhance beneficiary satisfaction, facilitate the delivery of health care services, and further improve the quality of care delivered.

## **FFS Benefits – Durable Medical Equipment (DME)**

MHPA notes that most states have already have adopted the Medicare DME guidelines. For this reason, MHPA recommends that CMS require that all state Medicaid plans adopt guidelines based on utilization and InterQual standards, as they are clinically sound and well-researched. In addition, MHPA recommends that the DME fee schedules be standardized, and crossover payments standardized for all copay amounts, to ensure that Medicare DME providers are paid in full for duals. This will reduce the likelihood that beneficiaries become caught in the middle between their provider's payment expectations and the state's willingness to pay crossover claims in excess of the Medicaid rate. MHPA further recommends that the capped rental and rent/purchase guidelines (described in the Medicare Claims Processing Manual, Chapter 20 – Durable Medical Equipment, 30.5, 30.5.1, 30.5.2) be strengthened, and that providers be held accountable for researching member history for purchased items.

## **FFS Benefits – Home Health**

MHPA encourages CMS to modify the Medicaid regulations at 42 CFR 484 and establish definitions for two levels of home health services for duals -- acute skilled/rehabilitative and chronic/custodial. Within each of these categories, CMS should identify appropriate levels of service for nursing, therapies, social work, nutrition consultation, and personal care that would be applicable to all enrollees regardless of state Medicaid program. Furthermore, home health provider certification for chronic/custodial and personal care should be standardized across all states. Dual members who receive chronic/custodial home care and personal care services should have integrated care plans, with the ability to insert acute/rehabilitation services as needed, without changing agencies. In addition, MHPA recommends CMS consider creating a prospective pay "case rate" payment for chronic/custodial home health services.

## **FFS Benefits – Nursing Home/Hospital Transfers**

While MHPA supports the use of appropriate safeguards to assure that overutilization does not occur, we recommend that CMS eliminate the current requirement (found at Medicare Benefit Policy Manual – Chapter 8: Coverage of Extended Care (SNF) Services Under Hospital Insurance,

20.1) that dual beneficiaries incur a three-day hospital stay before Medicare payment for skilled nursing facility care is authorized. This requirement, in our experience, is resulting in unnecessary and costly hospitalizations and is disruptive for beneficiaries. If a dual eligible member is a resident of a nursing facility funded by Medicaid, and an acute need arises that can be adequately treated at a higher level of care within the same facility, MHPA recommends that an intra-facility transfer be approved in lieu of a transfer to a hospital.

### **FFS Benefits – Skilled Therapies**

MHPA recommends that CMS standardize the credential definitions for skilled therapists – including all therapy professionals and paraprofessionals – between Medicaid and Medicare. We encourage CMS to ensure that Medicare and Medicaid rules contemplate and address skilled professional shortages and allow the use of appropriately supervised assistants (PTAs, OTAs) as extenders to facilitate access to care. Finally, MHPA believes that alternate pricing should be established when care is provided by a paraprofessional.

### **Prescription Drugs – Access for New Full Duals**

MHPA urges CMS to require that states submit eligibility data more frequently than monthly, perhaps daily or weekly. To avoid waste and operate more efficiently, MHPA encourages CMS to work with states to ensure they are promptly aligning their benefits for dual eligible members so that Medicaid only covers those drugs excluded by the Part D plans which are covered under the state benefit. This will help to eliminate cost shifting from the Part D program to Medicaid. It will also benefit Part D plan sponsors, as improved coordination would reduce the number of state subrogated claims that they receive retrospectively for payment.

### **Cost Sharing – Crossover Claims**

MHPA members have found that the effectiveness of paying crossover claims varies considerably by state. While some states have a process in place to automatically crossover payments, other states do not. Providers who are not part of an integrated plan can become confused over the type of member that is presenting, and will turn a dual eligible away because they are unaware that the member is Medicare primary. Members typically present a host of ID cards, and it can be burdensome for providers to sort through and interpret each card. Furthermore, many providers are unaware of the rule (found in the Provider Reimbursement Manual, Chapter 3, CMS Publication 15-1: Section 322) limiting payment of crossover claims to the lesser of Medicare out of pocket cost and the Medicaid fee schedule. Therefore, providers become dissatisfied when the crossover claims are denied by a state. This confusion and dissatisfaction impacts access to care as some Medicare providers refuse to treat dual eligible patients. This is inconsistent with many of the concepts set forth under the Affordable Care Act, such as Accountable Care Organizations, care coordination, and integrated, high performing networks.

MHPA believes that enrolling duals into a single, integrated health plan with a specialized D-SNP provider network that only includes providers that accept both Medicare and Medicaid

would substantially reduce provider dissatisfaction and access to care issues for beneficiaries. We note that plans would need two to three years to build these networks, but the investment in creating specialized D-SNP networks would provide a beneficial payoff for beneficiaries, providers, plans, and the programs overall.

### **Cost Sharing – Balance Billing for Qualified Medicare Beneficiaries**

MHPA members' experience reveals that balance billing remains a substantial problem for dual eligible beneficiaries. Many Medicare providers either do not realize a patient is dually eligible or do not know that balance billing is prohibited and proceed to charge them for Medicare out-of-pocket costs. D-SNP members generally report these incidents to their plan and we take steps to educate providers. Nonetheless, balance billing remains prevalent. MHPA believes that enrolling duals into a single, integrated health plan with a specialized D-SNP provider network (that only includes providers who accept Medicare and Medicaid) would substantially reduce balance billing and encourages CMS to consider this model.

### **Enrollment – Re-certification Requirements**

Some states continue to require in-person re-certification for dually eligible Medicaid beneficiaries, which is an unnecessary administrative burden on the states and beneficiaries. Dual eligibles often face socioeconomic challenges, in addition to frailty and mobility issues, which make in-person re-certification difficult. The unfortunate end result of this burdensome process is eligible members have gaps in enrollment and therefore gaps in care.

There are several states that have made progress with facilitating re-certification by using data available from other public programs like Social Security to continue eligibility for dual eligibles while the recertification process is completed. However, there are more options available and simplified re-certification processes should be in place across all states. MHPA recommends that CMS examine the considerable literature on best practices in simplifying re-certification for Children's Health Insurance Program (CHIP) enrollees, and mandate that states provide passive re-certification options for beneficiaries. Some examples currently being used with great success in CHIP include: *ex parte* review of information already available; pre-populated, simplified re-enrollment forms that enrollees simply need to update, sign, and return; eliminating unnecessary documentation; or using technology to permit online processing and e-signatures for renewal applications or gathering of information from existing primary data records (e.g., social security).<sup>3</sup> MHPA urges CMS to require that states use a passive re-certification process to minimize unnecessary enrollment and care gaps and assure consistency for dual eligible beneficiaries in all states.

### **Enrollment – Medicare Savings Program Asset Test**

MHPA encourages CMS to drive efficiencies by developing one nationwide set of rules for asset testing of potentially eligible duals that must be applied uniformly by the states.

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<sup>3</sup> Maintaining Coverage for Children: Retention Strategies. *Georgetown University Health Policy Institute Center for Children and Families*. March 2009.

## **Appeals – Timeframes for Filing and Appeal Related to Benefits**

Medicaid rules permit a beneficiary up to 90 calendar days from an action to file an appeal, while Medicare Advantage rules permit 60 calendar days. These differing timeframes are administratively burdensome and confusing for all parties, and can unnecessarily delay the provision of needed health care services. For example, in states with integrated D-SNPs, such as New York, enrollees have a two-track appeals process. Members who appeal benefit coverage decisions made by a health plan have the right to appeal to either CMS or the State of New York if the benefit is paid for by both. Benefits covered only by State funds are eligible for appeals only via the State process.

MHPA recommends that CMS adopt the current Medicare Advantage timeframes of 60 calendar days to file an appeal for all dual eligible beneficiaries. We support identifying a mechanism to permit a State to be involved in this process to the extent necessary. We believe the Medicare Advantage timeframes represent a best practice and balances the beneficiaries' needs with the health plan's business processes. The 60 day timeframe ensures that appeals are filed sooner rather than later. This is especially important when an enrollee is waiting for the service and the provider is filing on behalf of the member. Using different timeframes for the same member for the same denial and appeal request is administratively burdensome.

## **Appeals - Access to State Level or External Review**

MHPA recommends that CMS use the Medicare Advantage Independent Review Entity (IRE) for all dual eligible beneficiaries. The IRE process requires that medical necessity reviews be auto-forwarded by the plan for external review. Adverse decisions which are administrative in nature are not automatically forwarded by the plans. Instead, appellants must request that they progress to the next level.

## **Appeals - Continuation of Benefits (COB) Pending Appeal**

Should CMS elect not to pursue an integrated D-SNP as the model of care for duals, MHPA recommends that CMS adopt the Medicare Advantage model for COB. The Medicaid model is difficult to administer because, in most instances, the beneficiary must make a request for COB to occur. The process of requesting COB while an appeal decision is pending is confusing for beneficiaries. Additionally, most members do not continue their treatments during the appeals process because the Medicaid rules state that the plan may seek recovery if the appeal decision is adverse. Under Medicare, while benefits generally do not continue, the physician can request an expedited review of 72 hours if discontinuing benefits would be detrimental to the beneficiaries' health.

## **Appeals - Document Notifying Beneficiaries of Appeal Rights**

Currently, under Medicaid, each plan is allowed to develop its own "notice of action" letters and the format for these notices can differ across health plans. Medicare Advantage, however, relies upon a "model" notice document that is consistent for all beneficiaries regardless of

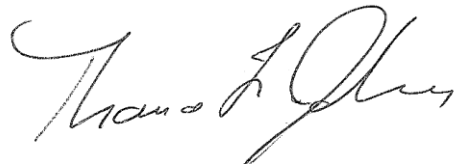
health plan. MHPA encourages CMS to adopt the Medicare Advantage process and establish a model document for duals that incorporates the Medicare Advantage process and, at the same time, meets NCQA and URAC requirements.

**Appeals - Timeframe for Resolution of an Appeal Related to Benefits**

MHPA recommends that CMS generally adopt the current timeframes applied under Medicare Advantage for standard appeals (30 days for pre-service and 60 days for payment appeals). For expedited cases, MHPA recommends that the wording reflect “3 business days” as opposed to “72 hours.” Additionally, MHPA recommends that CMS retain the provisions permitting extensions for pre-service appeals. This approach uses the Medicare Advantage as a best practice baseline and appropriately balances the beneficiaries’ needs with the health plan’s business processes.

Thank you for the opportunity to respond to the Request for Information. Please contact me at 202-857-5725 or [tjohnson@mhpa.org](mailto:tjohnson@mhpa.org) with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas L. Johnson". The signature is fluid and cursive, with the first name being the most prominent.

Thomas L. Johnson  
President & CEO