HEALTH PROJECT
Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, BPC’s Health Project seeks to develop bipartisan policy recommendations that will improve health care quality, lower costs, and enhance health care coverage and delivery. The Health Project focuses on coverage and access to care, delivery system reform and cost containment, and long-term care.

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Introduction

On February 8, 2018, President Donald Trump signed the Bipartisan Budget Act of 2018 (BBA 2018), which included important changes to the Medicare program for individuals with multiple chronic conditions. The changes were designed to improve quality of care and lower Medicare costs for patients who may also need help with day-to-day activities, such as bathing or dressing. Generally, these are adults with complex care needs. Under BBA 2018, Medicare Advantage (MA), Medicare’s managed care plans, may provide additional or supplemental services to those with complex care needs. This new flexibility for health plans has significant potential to provide access to non-medical health-related benefits, including those that have proved successful in keeping patients in their homes. Rather than a cycle of emergency department visits, hospital admissions, and discharges to home, MA plans beginning in January 2020 may target services such as minor home modifications to help accommodate walkers or wheelchairs or home-delivered meals that are lower in salt or sugar for those with diabetes or chronic heart failure. The law also included language to better align care for those who have both Medicare and Medicaid, among a number of other provisions.

Full accomplishment of the law’s goals depends on a number of factors. The law provides considerable discretion to the secretary of the U.S. Department of Health and Human Services (HHS) on how, and in some cases whether, to implement provisions of the law. Within HHS, the Centers for Medicare and Medicaid Services (CMS) will serve as the lead agency for implementation. In addition to agency decision making, the failure or success of the law will also be determined by the willingness of MA plans to try innovative approaches to care, and whether states and plans commit to the integration of Medicare and Medicaid.

This issue brief explores the key decisions CMS, health plans, and states, will make in determining how to implement the law. The Bipartisan Policy Center gathered information through a series of roundtable discussions, public events, and individual interviews with stakeholders, including current and former agency officials, congressional staff, health plan administrators, state officials, consumer advocacy organizations, and other experts.
Background: Improving Care and Lowering Cost for Adults with Complex Care Needs

Federal policymakers, in seeking solutions to address rising costs in health programs such as Medicare and Medicaid, recognize that both the number of Americans over age 65 with multiple chronic conditions and the cost of providing care is increasing. These older Americans often have difficulty performing everyday tasks, such as bathing, dressing, or safely ambulating around their homes. According to the Centers for Disease Control and Prevention, one in four Americans lives with multiple chronic conditions, and for those over age 65, that number increases to three in four. Medicare beneficiaries with four or more chronic conditions account for 90 percent of Medicare hospital readmissions and 74 percent of overall Medicare spending. With an estimated doubling of the number of older Americans by 2050, the rapid change in demographics will place significant strain on the nation’s health care system.

Average Annual Medicare Spending per Beneficiary by Number of Chronic Conditions (Medicare-Only Beneficiaries – 2015)

Medicare beneficiaries with four or more chronic conditions account for 90 percent of Medicare hospital readmissions and 74 percent of overall Medicare spending.

Medicare beneficiaries who are also eligible for Medicaid are especially vulnerable—and especially costly. “Full-benefit” Medicare-Medicaid beneficiaries, those who are eligible for all Medicaid-covered benefits, as opposed to those who receive only Medicare premium and cost-sharing assistance, have risk scores that are 50 percent higher than the average for all other Medicare beneficiaries. The average full-benefit Medicare-Medicaid enrollee has six chronic conditions, while all other Medicare beneficiaries average four chronic conditions. In 2011, just one-tenth of the full-benefit Medicare-Medicaid population accounted for 38.5 percent of total combined Medicare and Medicaid spending for that group. The high cost of care and lack of coordination has led policymakers to take steps to lower costs and improve quality of care for adults with complex care needs.
PROMOTING EVIDENCE-BASED CARE

Successful care models that serve adults with complex care needs have certain elements in common. First, they target populations by age group with multiple chronic conditions, and by those who have a history of high cost and utilization of services. Other common care approaches of these models include interdisciplinary care teams that communicate frequently to manage patient care; chronic disease self-management, in which patients and their families play a role in care management; focusing on transitions from hospitals or post-acute care settings to homes; and seeking to better integrate care by addressing risks such as inadequate food, housing-related services, transportation, and other non-medical health-related benefits.

Despite what health care experts have learned about successful programs, evidence-based delivery models have not spread and scaled. A 2017 BPC report identified five barriers to widespread adoption, including:

- existing uniform benefit requirements for MA plans, which require health plans to offer the same benefits to all enrollees;
- benefit-specific restrictions on MA plans’ supplemental benefit offerings;
- rules governing the calculation of medical loss ratios for MA plans;
- program integrity rules relating to beneficiary inducements and the Anti-Kickback Statute; and
- uncertainty in the adequacy of Medicare financing.

Federal law, including regulations and agency guidance, can prove to be significant barriers to transformation of care for adults with complex care needs. While HHS is testing new payment and delivery models that provide increased flexibility to providers, and the Medicare Access and CHIP Reauthorization Act of 2015 included provisions encouraging physicians to participate in value-based payment models, the majority of adults with complex care needs remain in traditional fee-for-service Medicare, which does not support these types of successful care models. Enactment of the chronic care provisions of BBA 2018 may serve to eliminate a number of these policy barriers, including the ability to target non-medical, health-related benefits to patients with chronic conditions.

Coordinating and integrating services and supports is critical to improving quality and lowering costs of care for adults with complex care needs. Medicare-Medicaid beneficiaries have a higher prevalence of most chronic conditions than those who qualify only for Medicare, yet most of these individuals do not have integrated care. Oftentimes, patients face multiple sets of benefits and rules, making it difficult to navigate their care. In some cases, a Medicare-Medicaid beneficiary will enroll in up to five different managed care plans: one for Medicare medical services, one for Medicaid medical services, one for managed long-term services and supports (LTSS), one for behavioral health services, and one for dental services. About 400,000 individuals are enrolled in more than one limited benefit plan. The potential for harm to patients, confusion, inability to access care from the correct plans or providers is significant, and America’s most vulnerable individuals deserve better.

BIPARTISAN BUDGET ACT OF 2018

The chronic care provisions of BBA 2018 are based on the work of the Senate Finance Committee’s bipartisan chronic care working group and on previous work by the House Ways and Means and Energy and Commerce Committees. While policymakers have accomplished the difficult work of legislative enactment, implementation of the new law will have a significant impact on its success, especially given that the HHS secretary has considerable discretion when it comes to implementing certain provisions. For example, in many cases, the new flexibility exists, yet it is contingent upon the secretary determining that certain actions are “feasible.” This issue brief discusses three key areas in which CMS will face key decisions that could impact the implementation of the chronic care provisions. In preparing this brief, BPC sought feedback from a broad range of stakeholders, including current and former agency officials, state officials, health plan administrators, health care providers, patient advocacy organizations, and other experts.
While BBA 2018 included a number of provisions related to patients with chronic conditions (outlined below), this report limits its scope to the implementation of three important areas of the new law:

1. The ability for MA plans to better target supplemental benefits to enrollees with multiple chronic conditions and to cover non-medical, health-related services such as transportation, meals, and minor home modifications.

2. New requirements to better integrate Medicare and Medicaid services for those dually eligible for both programs.

3. Alignment of the grievance and appeals processes for Dual Eligible Special Needs Plans (D-SNPs).

**KEY CHRONIC CARE CHANGES**

BBA 2018 incorporated chronic care provisions from both the House and Senate. Members of Congress and their staffs devoted hundreds of hours to talking with patient groups, health care providers, and other experts, including BPC, to develop health policy that would both hold down costs and help patients and their families get the care they want and need.

**Senate Action**

BBA 2018 included many provisions of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, which previously passed the Senate with unanimous support. Senate Finance Committee Chairman Orrin Hatch (R-Utah) and Ranking Member Ron Wyden (D-Ore.) introduced the CHRONIC Care Act of 2017, which included the work of the Senate’s chronic care working group. Hatch and Wyden formed the working group, which Sen. Johnny Isakson (R-Ga.) and Sen. Mark Warner (D-Va.) led.

**House Action**

The House Ways and Means Subcommittee on Health held a chronic care hearing and approved several bills in June and July 2017, and along with the House Energy and Commerce Committee worked to incorporate provisions from multiple bills into budget legislation. The House work on chronic care was based on multiple pieces of legislation, mostly introduced by members of the two committees, to extend and strengthen MA Special Needs Plans (SNPs), expand supplemental benefits for adults with chronic care needs, include telehealth services as a basic benefit for Medicare Advantage enrollees, and to extend through 2019 the Independence at Home demonstration program. On July 13, 2017, the House Ways and Means Committee approved legislation to reauthorize SNPs and to improve access for adults with complex care needs. Then-Ways and Means Health Subcommittee Chairman Patrick Tiberi (R-Ohio) and Ranking Democrat Sander Levin (D-Mich.) introduced the legislation. Much of the House committee work was rolled into BBA 2018.

**The New Law:**

1. Allows MA plans greater flexibility in targeting services to patients with multiple chronic conditions by offering coverage of non-medical health-related services and supports. Examples include things like home-delivered meals and minor home modifications, such as grab bars and ramps.

2. Permanently extends the MA SNPs to support millions of vulnerable Americans who are eligible for Medicare and who, because they are low-income, are also eligible for Medicaid to cover Medicare cost-sharing and services not covered by Medicare, including LTSS.

3. Better aligns regulatory authority for SNPs within HHS by providing greater authority for the Medicare-Medicaid Coordination Office within CMS, an office specifically created to address the special needs of Medicare-Medicaid beneficiaries, also known as “dual-eligible” individuals.

4. Requires SNPs to better integrate care for Medicare-Medicaid beneficiaries by covering all services in a single managed care plan, better coordinating care, and eliminating confusion for patients enrolled in one plan for health services, another for long-term care, and a third for behavioral health. In addition, CMS must include unification of the grievance and appeals processes for SNPs to provide a single set of rules for plans, providers, and beneficiaries.

5. Extends the successful Independence at Home Demonstration program for two years to help seniors access quality, team-based care at home.

6. Expands access to telehealth services under MA, in certain accountable care organizations (ACOs), and for dialysis and stroke patients.
Key CMS Decision Points

In developing agency guidance, CMS will make a series of important decisions. Based on research and stakeholder engagement, CMS must address a number of issues to ensure successful implementation. Among them:

CMS will need to strike the appropriate balance between providing a sufficient level of flexibility to allow plans to determine what types of supplemental benefits to offer and providing a sufficient level of guidance so that MA plans feel comfortable offering services without fear of audits or sanctions.

Given the lack of a strong evidence-base demonstrating return on investment in non-medical supplemental services and the preferences of individuals and their families to receive care in the community, CMS should collect data to determine the effectiveness of this new benefit flexibility.

CMS will need to ensure that plans do not use new supplemental benefits to select or avoid risk. One approach could be to prohibit the use of supplemental benefits in the marketing of plans. This is especially important as policymakers consider expanding to other payment and delivery models, where risk selection will be an even bigger factor.

CMS should, in setting guidelines for integration, consider previous work done in conjunction with the private sector, which developed a list of key elements of integration, including enrollee assessments, care planning, organization and operation of care teams, the management of care transitions from one setting to another, and communications between providers.

CMS should consider existing beneficiary relationships with plans and providers in setting standards for integration of Medicare and Medicaid services. Some states or plans may not have experience in serving Medicare-Medicaid beneficiaries, and will need some form of “glide path” toward full integration, one that moves toward integration of services without disrupting care coordination, where it is available today.

CMS should consider more meaningful shared savings as a means to encourage states to better coordinate care for Medicare-Medicaid beneficiaries, and it should draw on lessons learned from existing care models and demonstrations underway through the financial alignment initiative.
Non-Medical Supplemental Benefits

CMS will need to determine whether to define a limited set of supplemental benefits that plans may offer to patients with chronic conditions, or whether to allow plans to notify CMS as to what types of supplemental benefits they plan to offer. A primary reason for non-medical supplemental benefits is to lower overall costs, and some evidence is beginning to emerge. A recent study published in the journal Health Affairs shows a promising connection between meal supports and lower health care costs. As part of the study, certain individuals enrolled in both Medicare and Medicaid received lunches, dinners, and snacks delivered to their homes for six months. In some cases, the meals were specialized to meet the needs of individuals with diabetes, hypertension, or other conditions. Across the board, participants had lower health care expenses. Medical spending for individuals receiving medically tailored meals was $843 per month, compared with $1,413 for individuals not receiving meals. After deducting the cost of the program, participants saved an average of $220 per month. The savings was less for those individuals receiving non-tailored meals. The study also found that individuals receiving meals had fewer hospital admissions and trips to the emergency room.

While Medicare Advantage Dual-eligible Special Needs Plans (D-SNPs) have experience in serving adults with complex care needs, including those who qualify for LTSS, it is unclear whether traditional MA plans would be willing to—or have the expertise to—offer new benefits to these adults. Today, most MA health plans offer beneficiary cost-sharing benefits, such as lower co-pays or deductibles, or other benefits designed to encourage enrollment, primarily hearing aids, eyeglasses, and prescription drugs. The new law opens the door to non-medical, health-related services, such as transportation, meals, and home modifications, and health plans may determine that some make economic sense and others do not. For example, an MA plan may determine that providing minor home modifications, such as ramps and grab-bars, may prevent falls and keep people with functional limitations out of the emergency room. It may be harder for them to justify the return on investment for something such as utility bills during hot summer months for someone at risk of repeated hospitalization for heat exhaustion.

Key Implementation Decision Points

- What level of flexibility will CMS provide to plans to offer supplemental benefits?
- How should administrators collect data to build an evidence-base for the targeting of supplemental benefits?
- Where evidence is available, should CMS provide incentives for plans to offer these benefits?
- What level of flexibility will CMS provide to plans to target services to enrollees?
- Could the provision of supplemental benefits be used to select or avoid risk? How could risk-selection be avoided?
As part of implementation CMS could help build an evidence base for providing supplemental services by collecting data on the costs and associated savings of providing supplemental benefits. Consumer advocacy organizations have raised questions as to whether CMS might consider incentives to plans to provide evidence-based supplemental services by incorporating them into quality measurements. “Finally, CMS should be able to draw from MA plans’ responses to the limited flexibility that CMS provided under existing agency authority for plan year 2019.”

Eligibility

CMS will need to address which enrollees qualify for certain supplemental benefits. The new law allows the HHS secretary to waive the uniform benefit requirement so that MA health plans aren’t required to make the new benefits available to all enrollees. This would permit plans to target supplemental benefits to the individuals who most need them. One question is: Will CMS decide which enrollees qualify for supplemental benefits, or will they, within a framework, permit plans to decide? This decision could have a significant impact on whether plans offer supplemental benefits, since two people with diabetes or hypertension may have different functional limitations and may not need the same supports.

Basing eligibility on diagnosis might deter health plans from offering benefits because they would have to make them available to people who may not need them. Although some argue that plans already have the authority to distinguish between patients through the use of existing plan provisions that require that services be medically necessary, some plans have raised concerns that there will be a reluctance to do so because of concerns about challenges to plans and potential audits. Basing eligibility on functional limitation may align needs with benefits. That could mean measuring an enrollee’s needs based on his or her activities of daily living—such as the ability to prepare food and feed oneself, to drive oneself, or to use public transportation—would give plans greater security in targeting benefits.

Some consumer advocates have expressed concern that allowing for the provision of supplemental benefits could result in risk selection. Specifically, there is concern that plans would add benefits that would attract younger, healthier individuals. In the early years of MA plans offerings, for example, there was a concern about marketing to seniors and offering benefits such as gym club or golf club memberships. While the law could create opportunities for health plans to risk select, or fashion benefits that attract healthier enrollees and/or deter costly individuals, the new law attaches some conditions to the new flexibility. First, benefits must be targeted to patients with multiple chronic conditions, who by definition tend to be higher-risk individuals. There are other limitations that CMS could use to deter risk selection, such as prohibiting plans from marketing to beneficiaries based on the new supplemental benefits. This will be especially important for provider-sponsored organizations that may wish to offer supplemental benefits. The law also clarified that ACOs may offer supplemental benefits. This is another area that will need to be closely monitored to ensure that provider organizations offer supplemental benefits only to those with multiple chronic conditions; policymakers may want to consider adding a functional or cognitive impairment requirement. Further, ACO providers should not be permitted to market based on supplemental benefits. Another way to address this issue would be to continue the movement toward an enrollment-based ACO model, rather than an attribution model, with patients enrolling in ACOs in the same manner in which they enroll in MA plans. These recommendations were promoted by BPC’s leaders in 2013 and 2015.
IMPROVING INTEGRATED CARE FOR HIGH-NEED PATIENTS

WHO THEY ARE
Roughly 10.3 million low-income, elderly patients and individuals with disabilities qualify for both Medicare and Medicaid coverage. Dual-eligible beneficiaries are often sicker than other patients, have significant functional and cognitive impairments, and have greater need for care coordination and assistance with activities of daily living.

PREVALENCE OF CHRONIC CONDITIONS*

<table>
<thead>
<tr>
<th>Condition</th>
<th>All Other Medicare Beneficiaries</th>
<th>Full-Benefit Dual-Eligible Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>36%</td>
<td>62%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>14%</td>
<td>19%</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>12%</td>
<td>19%</td>
</tr>
<tr>
<td>Any behavioral or cognitive impairments</td>
<td>10%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Source: Acumen LLC Analysis Performed on Behalf of BPC. 2016.
*(CY 2011)

DUAL-ELIGIBLE BENEFICIARIES HAVE A HIGHER RISK OR RE-HOSPITALIZATION

1/2 of all Medicare patients with chronic obstructive pulmonary disease and congestive heart failure are hospitalized at least once during the year, but of these patients, dual-eligible individuals are about two times as likely to return to the hospital multiple times during the year.

DUAL-ELIGIBLE BENEFICIARIES FACE BARRIERS TO RECEIVING INTEGRATED CARE

- 2–5 Enrollment cards
- Processes & Contact Numbers for Coverage Appeals
- Sets of Rules for Benefits & Cost-Sharing
- Enrollment Periods & Deadlines for Applications
**MEDICARE AND MEDICAID INTEGRATION**

SNPs are MA coordinated care plans that provide targeted services to individuals with special needs. Within the SNP category, C-SNPs enroll individuals with chronic conditions, I-SNPs enroll individuals in institutions, and D-SNPs enroll individuals who are dually eligible for both Medicare and Medicaid. Prior to enactment of BBA 2018, MA-SNPs were authorized for a time-limited period, beginning with establishment of the plans in 2003. Some health plan administrators argued that these short-term authorizations did not provide sufficient guarantees of long-term viability and created a disincentive for them to invest in infrastructure, personnel, or certain services.

In addition to permanently authorizing SNPs, the law directs the HHS secretary to set standards for integration of Medicare and Medicaid services. Those plans that are integrated as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) have contracts with both the federal government to offer Medicare services and states to offer Medicaid services. In addition, 11 states participate in the Financial Alignment Initiative (FAI), a demonstration that requires states to offer, with a few exceptions, all covered Medicare, Medicaid, behavioral health, and LTSS through a single health plan. By 2021, D-SNPs are required “to the extent feasible” as determined by the HHS secretary, to integrate LTSS and behavioral health into their care models.

### Key Implementation Decision Points

- What factors will CMS use to define and determine integration of care?
- Must an integrated health plan be a single entity, or can two or more plans sufficiently coordinate to offer an integrated benefit?
- How will CMS treat plans that fail to integrate by 2021? If CMS terminates those plans, what happens to plan enrollees? Requiring plans to be single entities may lead to the exclusion of some effective D-SNPs, and some may not be able to fully integrate by 2021. Where no behavioral health managed care plans exist, plans could be required to offer behavioral health services. Is it possible to develop a “glide-path” to integration over a period of several years?
- How will CMS guide state Medicaid plans about how to move forward with Medicare-Medicaid beneficiaries who are participating in demonstration projects scheduled to end in 2020?
- Will states that do not currently offer Medicaid benefits through managed care decide to permit managed care in their states for a high-risk population? This is especially important in states that do not have experience serving this population, or where health plan administrators do not have adequate experience.

The new law promises to reduce confusion for enrollees who may have one health plan for Medicare-covered services and one or more plans for health-related Medicaid services, behavioral health services, and LTSS. However, much depends on how CMS defines integration.

CMS will need to decide whether integrated plans must be a single entity or appear to be an integrated entity from the perspectives of consumers and providers. A single point of contact could determine which program covers the service and guide the individual through the process. Still, it is unclear whether it is possible to create or even how to create a single pathway and point of communication for a Medicare-Medicaid enrollee.

The most integrated option entails a single health plan that contracts with both the state and federal government and that covers all Medicare- and Medicaid-covered services. A report published by the Long-term Care Quality Alliance in 2016 outlined ways to determine key factors in care integration by plans, including enrollee assessments, care planning, organization and operation of care teams, the management of care transitions from one setting to another, and communications between providers. These and other factors will play an important part in determining how best to integrate care. One way of assuring consideration of these factors could follow the approach used by CMS under the FAI, in which plans enter into a single “three-way” contract with a state to provide all services. Critical to this approach is the state agreeing to enroll Medicare-Medicaid beneficiaries into managed care plans. If a state refuses to do so, plans will find it difficult, if not impossible, to integrate Medicaid fee-for-service benefits.

One concern raised by states is that there is insufficient return on state investment for enrolling patients in D-SNPs, since investments designed to lower costs typically require investment in Medicaid-covered services (jointly funded by states and the federal government). Savings typically accrue in the form of reduced emergency department visits and reduced hospital admissions, in which case the savings goes solely to the federal government through Medicare.
GRIEVANCE AND APPEALS

When appealing a coverage decision or filing a grievance, Medicare-Medicaid beneficiaries currently must navigate two different processes, and the programs have important differences. To further complicate the situation, Medicaid procedures vary from state to state. It is often unclear which program is covering which service, and therefore which set of procedures applies. These differences create barriers to integrated care. Indeed, individuals must work through disparate time lines, and sometimes they miss out on important services while they wait for decisions.

The new law also requires the creation of a unified process by which Medicare-Medicaid beneficiaries may appeal coverage and payment decisions. It calls for a single pathway for resolution of any grievance or appeal and a unified time frame for the process. By April 1, 2020, the HHS secretary must establish procedures, and by 2021, all contracts with specialized MA plans must include them. CMS must adopt the procedures that are “most protective for the enrollee.”

Key Implementation Decision Points

- Which appeals processes should CMS adopt from Medicare, which from Medicaid, and how will CMS account for Medicaid differences from state to state?
- Will the flexibility that the law grants to the HHS secretary keep the department from fully unifying the grievance and appeals procedures?

BBA 2018 provides the HHS secretary with some flexibility by requiring unification only “to the extent feasible,” and most experts expect unification to be a difficult task, given the variability in Medicaid programs from state to state.

Differences between Medicare and Medicaid grievance and appeals procedures include:

- Health plan role: Medicare requires beneficiaries to appeal first to the health plan. This is also the case with some Medicaid plans, although others allow beneficiaries to appeal directly to the state.
- Continuation of benefits: Medicare beneficiaries do not receive benefits while the appeal is in process. Medicaid beneficiaries, however, may request continued services while they await a decision.
- Amount in controversy: Medicare beneficiaries can’t escalate the appeal beyond the health plan if the amount in controversy is less than $50. Most Medicaid states have no such provision. Medicaid beneficiaries have lower incomes, so the financial threshold is not appropriate.
- Right to an in-person hearing: In most cases, Medicare beneficiaries appeal by phone. Medicaid beneficiaries, though, have the right to a “fair hearing” and may appear in person. While consumer advocates maintain that an in-person meeting is an important right for individuals, and often makes a difference in the outcome, some health plan administrators argue that the system becomes a problem when individuals miss meetings, as that can delay the process.
- Time line: The process is typically longer in Medicare, and the time line varies from state to state for Medicaid.

New York and Minnesota already have unified appeals processes for fully integrated D-SNP contracts. In Minnesota, the D-SNP plan determines whether a service is covered by either program. The plan uses a single time line and one denial notice if neither program covers the service. New York unified appeals through its financial alignment initiative. After accessing the health plan’s internal appeals process, beneficiaries are entitled to a fair hearing. The time line is the same, and beneficiaries may ask for continued benefits pending appeal. Denials at the plan level automatically escalate to an integrated administrative hearing officer, and benefits continue during the process. The beneficiary may escalate a negative decision further, where federal hearing officers consider both Medicare and state Medicaid law.
Conclusion

The chronic care provisions of BBA 2018 mark an important first step in improving care and lowering costs for adults with complex care needs. As the population ages and lives longer with complex care needs, the necessity for innovative approaches will be increasingly important. Congress and regulators can and will continue to develop policies in this area. CMS has already begun gathering input for the implementation of a unified grievance and appeals process. In March of 2018, the Medicare-Medicaid Coordination Office issued a request for input from stakeholders on both integration and alignment of the grievance and appeals process.

In developing agency guidance, CMS will make a series of important decisions. Based on research and stakeholder engagement, CMS must address a number of issues to ensure successful implementation. Among them:

**CMS will need to strike the appropriate balance between providing a sufficient level of flexibility to allow plans to determine what types of supplemental benefits to offer and providing a sufficient level of guidance so that MA plans feel comfortable offering services without fear of audits or sanctions.**

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*CMS should consider more meaningful shared savings as a means to encourage states to better coordinate care for Medicare-Medicaid beneficiaries, and it should draw on lessons learned from existing care models and demonstrations underway through the financial alignment initiative.*
Endnotes

1 Note: CMS has provided some flexibility based on pre-BBA authority, beginning in January 2019. However, broader regulations for implementing the BBA will be included in 2020 guidance to plans.


4 Ibid.


6 Ibid., 58.


Notes
The Bipartisan Policy Center is a non-profit organization that combines the best ideas from both parties to promote health, security, and opportunity for all Americans. BPC drives principled and politically viable policy solutions through the power of rigorous analysis, painstaking negotiation, and aggressive advocacy.