National
MLTSS
Health Plan Association

November 20, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Ms. Amy Bassano
Director
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
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RE: Centers for Medicare & Medicaid Services: Innovation Center New Direction Request for Information (RFI)

Dear Administrator Verma and Director Bassano:

The National MLTSS Health Plan Association is responding to the request for information (RFI) from the CMS Innovation Center (CMMI). The National MLTSS Health Plan Association is an association of health plans that contract with states to provide managed long-term services and supports (MLTSS). Our members currently cover about 75 percent of enrollees in MLTSS plans and about 50 percent of enrollees in Medicare-Medicaid plans (MMPs). MLTSS plans assist States in delivering high-quality services at the same or lower cost as the fee for service system with a particular focus on ensuring beneficiaries quality of life and ability to live in the community instead of an institution. Member organizations include Aetna Inc., AmeriHealth Caritas, Anthem Inc., Centene Corp., Commonwealth Care Alliance, Health Plan of San Mateo, L.A. Care Health Plan, Molina Health Care Inc., Tufts Health Plan, UPMC Health Plan, and WellCare Health Plans Inc.

The CMMI "focus areas" most relevant to the Association's priorities are:

1. ***Medicare Advantage (MA) Innovation Models***
   "CMS seeks to provide MA plans the flexibility to innovate and achieve better outcomes. ... CMS is also interested in what additional flexibilities are needed for supplemental benefits that could be included to increase choice, improve care quality, and reduce cost."

   MLTSS Association Comments:
   Medicare beneficiaries with functional limitations and multiple chronic conditions have annual medical expenses that are twice that of the population with multiple chronic conditions and no functional limitations. Currently, LTSS is only covered through the Medicaid program. Limited,

small-scale testing of integration of LTSS with medical coverage in the Medicare program could prove to have a substantial impact in lowering medical utilization and Medicare's cost of care for these high-need populations.

- CMMI should test a targeted, integrated, self-directed LTSS supplemental benefit in Medicare.
    - The benefit should be structured as a capitated supplemental payment to the plan that would cover comprehensive assessment for Medicare members with LTSS needs, benefits based on level of functional need, and flexibility for the plan to provide the services most appropriate for the individual member's needs.
    - The supplemental LTSS benefit could also be tested with ACOs and other payment models in which providers assume population risk.
    - The supplemental LTSS benefit in Medicare should be tested to measure its total impact not only on Medicare spending and outcomes, but also on preventing Medicaid spend-down for Medicare beneficiaries with functional needs.

- Models could allow states and more highly integrated health plans, like FIDE-SNPs and D-SNPs coordinating with Medicaid plans, to test the delivery of services to individuals dually eligible for both Medicare and Medicaid ("Duals") under certain regulatory flexibilities. Similar to the structure and goals of the Financial Alignment Initiative, these other health plans serving Duals could have the ability to test the positive impact that a single set of Medicare and Medicaid standards (i.e., unified appeals and grievances processes, unified beneficiary materials, a single coverage identification card, benefit flexibility, and other integrated elements) could have on effective, efficient operation of programs covering dually-eligible beneficiaries.

2. State-Based and Local Innovation, including Medicaid-focused Models

"CMS wants to partner with states to drive better outcomes for people based on local needs. … Healthcare providers and states would work with CMS to develop state-based plans and local innovation initiatives to test new models. Models could include providing states with more flexibility for multi-payer reforms as well as increasing opportunities for physicians serving Medicaid and/or CHIP populations to participate in value-based models. … Models specific to Medicaid populations would also be considered. CMS would rely on authority under sections 1115 and 1115A of the Act in developing and implementing such models."

MLTSS Association Comments:

The best opportunities for significant savings in both Medicare and Medicaid will come from testing and proving models that successfully manage care for the small percentage of the population in both that have the most complex care needs.

- CMS should continue and expand upon its partnership with states to test models that combine the resources of Medicare and Medicaid to integrate care for and better serve high-need, high-cost individuals with dual eligibility.

- The current financial alignment demonstration should be continued, improved and expanded.
- States should be given more flexibility to combine Medicare and Medicaid funding for Duals. CMS should test small-scale models that provide states authority over the use of Medicare funds in integrated approaches that combine Medicare and Medicaid resources, in those states that have both the interest and the capacity to test this type of arrangement.
- Plans should have greater flexibility within the capitated payment amount to provide whatever services and supports are most appropriate for the individuals they serve.
- Models should test alternative approaches to encouraging dually-eligible beneficiaries with the most complex care needs to enroll in plans that combine Medicare and Medicaid and integrate medical and non-medical services and supports.
  - CMS should give states the authority to require that dually-eligible beneficiaries in their state participate in an integrated plan.
  - CMS should explore a change in the current process that enrolls beneficiaries, by default, into fee-for-service Medicaid when they become eligible for Medicare but do not make an active enrollment selection.
- Models should also:
  - Test various payment structures, including improvements to risk adjustment to better account for higher-cost enrollees.
  - Evaluate improvements in outcomes, lower costs, and greater rebalancing of settings of care.
  - Include incentives for states to expand access to HCBS and build HCBS capacity and infrastructure. Enhanced access to HCBS will help members live more independently in the settings of their choosing as well as improve outcomes and quality of life while achieving cost efficiencies.

3. Mental and Behavioral Health Models

"CMS is actively exploring potential models focused on behavioral health, including opioids, substance abuse disorders, dementia, and improving mental healthcare provider participation in Medicare, Medicaid, and CHIP through integrated care and/or episode payment models."

MLTSS Association Comments:

Behavioral health needs are often interwoven with complex medical conditions and functional limitations. CMS should encourage states to participate in testing models that integrate medical, behavioral health, and long-term services and supports (LTSS) to effectively address this fabric of disabilities. Early examinations of programs that fully integrate benefits and care show that health outcomes can be improved and reduce total costs of care.

- As CMMI examines testing innovative approaches to improving care for those with mental health or substance use disorders (MH/SUD), we strongly recommend that

integrated approaches—not those that carve out MH/SUD—be the focus to test how integrated benefits and care impact health outcomes and total cost of care.

- CMMI should test an integrated MLTSS model that includes physical and behavioral health benefits and services, and that addresses social determinants of health that are related to health outcomes, such as housing, food insecurity, and employment supports.

- Features of a model that integrates physical and MH/SUD could include case management and other tools, to allow beneficiaries to navigate care and communicate with providers across the continuum.

- The model should be flexible enough to recognize the unique needs of diverse MLTSS populations (e.g. below and over 65 years, Dual and non-Dual, intellectual and developmental disabilities (ID/DD), behavioral health (BH) and substance use disorder (SUD), younger beneficiaries with disabilities that could benefit from employment and other supports).

The MLTSS Association further submits the following answers to specific questions posed by CMMI:

1. *Do you have comments on the guiding principles or focus areas?*

   Beneficiary choice is an important element that helps drive competition to lower costs and improve quality and outcomes. The choice between competing Medicare Advantage plans, for example, enables beneficiary preferences to drive plan behavior affecting the costs and quality of services.

   Not all choice, however, drives competition that can improve performance and outcomes. For beneficiaries with eligibility for both Medicare and Medicaid, a choice to remain in traditional, fee-for-service Medicare prevents individuals with complex care needs who make that choice from having access to plans that integrate Medicare and Medicaid benefits, provide high-quality care management and care coordination, and have been shown to lower costs and improve outcomes with high levels of member satisfaction. The difference for someone with complex care needs can be substantial.

   Few of the dually-eligible beneficiaries who make the choice to remain in traditional Medicare are aware of the foregone benefits of enrollment in an integrated plan. Often, they simply follow the advice of a service provider whose financial interests are served by keeping them in traditional Medicare. Beneficiaries who remain in traditional Medicare go on to generate the greatest per capita amount of Medicare spending.

   The most meaningful choice for those with dual eligibility is the choice that drives cost and quality – the choice between competing integrated plans. Duals should automatically have the benefits of Medicare and Medicaid integration that would provide them with lower costs and higher quality. The choice should be a choice of integrated plans – the kind of

choice that would ensure greater satisfaction and better outcomes while helping federal and state governments control health care spending.

2. *What model designs should the Innovation Center consider that are consistent with the guiding principles?*

   Choice, competition, person-centered care planning and care management, and greater flexibility to adapt interventions to respond to individual variations in needs are all critical components of successful model designs to serve individuals with the most complex care needs in the Medicare and Medicaid programs.

   CMMI's Financial Alignment Initiative (FAI), launched in 2011, is currently testing whether or not aligned payment and service delivery models reduce program expenditures under Medicare and Medicaid while preserving or enhancing the quality of care for dual-eligible beneficiaries.[1] Members of the National MLTSS Health Plan Association have 220,000 enrollees in their FAI Medicare Medicaid Plans (MMPs). Preliminary findings from the FAI show lower Medicare expenditures along with greater member satisfaction.[2,3,4]

   The Association recommends CMS use CMMI's demonstration authority to continue and extend by two years the current demonstration period. An extended demonstration period would allow any State with a FAI capitated model for Medicare-Medicaid beneficiaries additional time for evaluation reports and demonstration results to become available. CMS has previously granted two-year extensions to FAI demonstrations in three states (Massachusetts, Minnesota, and Washington). The Association recommends that CMS allow a similar extension for other states to allow the demonstration plans sufficient time to fully execute on some of the innovative concepts in the model proposal and evaluate the outcomes under a more State-led Medicaid administrative structure.

   The Association also recommends that CMS continue MMPs as a permanent plan type, overseen by MMCO once the demonstration period is over.

3. *Do you have suggestions on the structure, approach, and design of potential models? Please also identify potential challenges or risks associated with any of these suggested models.*

[1] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf
[2] https://innovation.cms.gov/Files/reports/fai-wa-finalyr1prelimyr2.pdf
[3] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FocusGroupIssueBrief508032017.pdf
[4] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAICAHPSResultsAug2017.pdf

Consistency of Consumer Protections Across Models:

The adequacy and consistency of consumer protections is critically important for models that provide greater individual choice and empower beneficiaries, families, and caregivers with flexibility and better information.

The past decade has seen a proliferation of models that support consumers with disabilities and their families with the integration and centralization of care coordination. Notably, models based on managed care have incorporated a comprehensive range of safeguards and protections to ensure that plan members receive clinical care and long-term services and supports that are necessary, appropriate, and effective. Important consumer protections include:

- marketing restrictions;
- person-centered planning requirements;
- network adequacy requirements;
- state and federal oversight to ensure delivery of contracted duties and high-quality services; and
- quality measurement, data, and evaluation to determine outcomes and inform consumer decision-making.

The Association believes consumers can be empowered most effectively, and make the best-informed choices, when these safeguards are applied uniformly across all models that are tested or available for enrollment. The Association recommends a basic uniform structure be applied across all models integrating care for persons with disabilities. This structure should permit significant program variation with respect to interventions to be tested while ensuring uniformity with respect to elements that are not unique to the intervention.

State Ability to Share Medicare Savings from Integration for Duals:

In plans that serve beneficiaries with Dual Eligibility for Medicare and Medicaid, the delivery and effective management of long-term services and supports (LTSS) that are covered by Medicaid often results in substantial reductions in emergency room visits and hospitalizations, generating savings for Medicare. Medicare savings, including savings generated from use of Medicaid home- and community-based services (HCBS) and other LTSS, can only be used currently to cover additional Medicare benefits; they cannot be shared with States to either reduce overall Medicaid expenditures, reduce wait lists, or enhance the Medicaid benefit structure.

The Association recommends that CMMI test a new model and payment approach for dual-eligible beneficiaries that would allow States that offer integrated Medicare and Medicaid plans to share in any Medicare savings that accrue from successful management of a dual-eligible beneficiary's Medicaid services, and use those Medicare savings to pay for Medicaid HCBS covered benefits where dollars are limited.

Access to HCBS to Enable People with Disabilities to Remain in the Workforce:

Our current system is structured to require people with disabilities who *can* work, *want* to work, and do not need income assistance, but cannot afford the services and supports they need to remain in the workforce, to *leave* the workforce and qualify for income assistance to get Medicaid in order to receive help paying for home- and community-based long-term services and supports (HCBS). The disincentive to work for people with a disability who receive Medicaid-funded HCBS is well-documented within the literature. These Americans and their families need a way to receive assistance paying for the costs of HCBS *without having to first* leave the workforce and qualify for Social Security Disability or SSI.

The Association recommends that CMMI test various models that incentivize Medicaid-funded HCBS beneficiaries to work, and document the savings accrued to Medicaid, Medicare, SSI/SSDI, and any other associated governmental benefits (including, but not limited to, SNAP and Housing Choice or Section 8 vouchers) through the various models.

Including Coverage for Housing to Improve Health Outcomes and Lower Costs

A lack of accessible, affordable, and community-integrated housing is a substantial barrier to health plans successfully supporting people with disabilities in lower-cost community-based settings. Without access to housing, beneficiaries who use LTSS and who want to live in a home or community-based setting cannot do so, and are often forced into higher levels of institutionalization at a much greater cost to Medicare and Medicaid. Although Medicaid funds can currently be used to reimburse certain "housing-related activities" in the community, existing statute does not allow the use of Medicaid funds for room (rent) in HCBS settings. Conversely, Medicaid funds *can* be used to support rent in institutional settings, and institutions in some states can get subsidized, guaranteed mortgages.

The Association recommends that CMMI partner with select States and health plans to test the overall effect on Medicaid costs and outcomes from reimbursing plans for the expense of room in a community setting.

7. *Are there any other comments or suggestions related to the future direction of the Innovation Center?*

CMMI has been a valuable mechanism for CMS, in partnership with States and health plans, to test innovative, integrated care models that reduce the complexity and conflicting regulations resulting from the attempt to combine two very different health care coverage programs for a single set of beneficiaries. The Association supports continuing to maintain CMMI's budget and broad demonstration authority.

Medicare-Medicaid integration is not simple; there are a range of integrated models combining resources and rules in different ways under different statutory authorities – including Medicare Advantage's Special Needs Plans (SNPs), Fully Integrated Dual-Eligible SNPs (FIDE-SNPs), PACE,

Medicare Medicaid Plans (MMPs), and Medicaid Managed LTSS (MLTSS) plans. Ultimately, the Association would like to see a common framework for integrated plans that provides uniformity across all models in some critical areas affecting competition, and allows variation in areas that reflect the needs of unique populations.

To advance a more uniform framework for integrated models, the Association recommends that CMS work in partnership with Congress to consolidate regulatory authority for reimbursement structures serving dual-eligible beneficiaries into a single office or center within CMS, such as the Medicare-Medicaid Coordination Office (MMCO, also known as Federal Coordinated Health Care Office). While MMCO is responsible for integrating care for dual-eligible beneficiaries, existing agencies within CMS retain regulatory authority over programs serving Duals. Consolidating this regulatory authority within MMCO will help ensure that decisions affecting these programs are made through the lens of an integrated program that takes into account the impact on beneficiaries, as well as state implementation.

Programs that would be brought under MMCO's authority would include existing SNPs, PACE, and current CMMI demonstrations that address this population, including the FAI demonstrations. Future integration demonstrations and the MMPs created by the FAI when they are made permanent should be included. Such an approach would allow Medicare and Medicaid experts from CMS to work together under a leadership team whose single focus is addressing the unique needs of low-income populations with complex needs, through an entity that has the authority to address those needs. This new structure would also be in line with the administration's Executive Order on cross-cutting reforms designed to create a leaner, more effective, efficient, and accountable government.

Sincerely,

G. Lawrence Atkins
Executive Director