National
MLTSS
Health Plan Association

January 12, 2018

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

**RE: CY2019 Proposed Policy and Technical Changes to the Medicare Advantage Program CMS-4182-P**

Dear Administrator Verma:

Thank you for the opportunity to provide comment on the Centers for Medicare and Medicaid Service's proposed rule *Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program*.

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 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. Responsibility for managing an LTSS benefit also extends to our members' offerings through dual-eligible special needs plans (D-SNPs) and Medicare-Medicaid Plans (MMPs). Member organizations include Aetna Inc., AmeriHealth Caritas, Anthem Inc., CareSource, 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 Plan Inc.

The Association supports efforts to move toward a more integrated and seamless system of care for all individuals, especially those who have dual eligibility for Medicare and Medicaid. Coordination of care across medical and non-medical sectors is critical to success in managing the quality of care, creating a seamless care experience for the individual and family, and managing state and the federal government expenditures. Integration of medical and LTSS coverage ensures individuals have the services and supports they need to remain independent in their homes and communities, and avoid unnecessary and expensive ER visits, hospital admissions and re-admissions, and institutionalization.

For these reasons, the Association supports a number of provisions in the proposed rule that would promote greater alignment of medical and non-medical coverage and encourage enrollment in aligned plans. We believe these changes will help MA special needs plans that serve beneficiaries with dual eligibility (particularly D-SNPs, FIDE-SNPs, and MMPs) achieve better coordination of medical and non-medical services and supports.

Please find below the Association's expanded comments and suggestions on the proposals referenced above.

***Flexibility in the Medicare Advantage Uniformity Requirements***

As described, CMS is proposing to allow MA plans to tailor cost sharing and benefits under Part C (excluding Part D) to enrollees who satisfy "specific medical criteria, provided that similarly situated enrollees are treated the same." Separately, CMS is proposing to allow MA plans to vary supplemental benefits by plan segment (i.e. county-by-county) so long as those supplemental benefits are uniform within the segment. As an example of the former, CMS provides a situation in which a plan may choose to offer diabetic enrollees a lower deductible or zero cost sharing for endocrinologist visits as compared to a more general population of enrollees.

The Association generally supports provisions that would provide greater flexibility in benefits and cost sharing to plans that hold the risk for meeting disability-related care needs. This proposal would provide greater flexibility to tailor the appropriate services and supports that meet the needs of individual beneficiaries. However, as CMS works to implement this provision and provides further guidance to clarify the flexibility offered, we would like to raise the following considerations:

- While CMS has indicated that it will allow plans to create population segments based on medical criteria (e.g. a diagnosis of diabetes or chronic heart failure), we would encourage CMS to consider also creating population segments based on functional capacity (i.e., ability to perform essential activities of daily living (ADLs)) or other non-medical criteria. Nearly half of all dual eligible individuals have functional limitations requiring LTSS[1] and often have unique needs that cannot be adequately addressed within the coverage restrictions of Medicare and Medicaid. D-SNPs, FIDE-SNPs, MMPs, or other plans that specialize in meeting complex care needs would benefit from having greater flexibility in defining the benefits and out-of-pocket costs to meet individual needs.
- The Association also encourages CMS to consider aligning its proposal with a provision to expand the definition of supplemental benefits found in the *Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act* (S.870) that is currently under consideration in the House and Senate. The provision would expand the definition of supplemental benefits to allow MA plans to offer chronically-ill enrollees supplemental benefits which would "improve or maintain the health or overall function of the chronically ill enrollee" and would "not be limited to being primarily health related benefits". We encourage CMS to incorporate this expanded definition of supplemental benefits and to consider expanding this flexibility beyond the chronically-ill population, using the CHRONIC Care Act as a model.

***Coordination of Enrollment and Disenrollment Through MA Organizations and Effective Dates of Coverage and Change of Coverage (§§ 422.66 and 422.68)***

As originally proposed, seamless conversion allowed for health plans operating a non-Medicare product to transition individuals into a Medicare Advantage plan offered by the same plan once a beneficiary became eligible for Medicare. In October 2016, CMS announced it would not grant additional plans permission to make these switches. CMS is now proposing to begin authorizing "seamless conversions"

[1] "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." MedPAC and MACPAC. January 2017. <https://www.macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf>

again under new requirements and limitations that have been developed based on beneficiary and stakeholder experience with the process. Under the new rules, CMS would limit the process of passively enrolling individuals through seamless conversion to individuals currently in a Medicaid plan who become Medicare eligible (and thus becoming dually eligible) into a D-SNP. CMS has proposed five requirements for this new process: (1) the individual of interest must be enrolled in a Medicaid managed care plan affiliated with the MA plan and they must be dually eligible for Medicare and Medicaid; (2) the state must have approved use of this default enrollment process and provided Medicare eligibility information to the MA organization; (3) the individual must not opt out of the default enrollment; (4) the MA organization must have provided a notice to the individual that meets CMS requirements; and (5) CMS must have approved the MA organization to use the default enrollment process before any enrollments are processed.

For those enrollees that do not meet the above guidelines (e.g. those with commercial coverage who become Medicare eligible), CMS proposes to create a new active (opt-in) election process through sub-regulatory guidance.

Seamless conversion has been an effective tool for enrolling individuals who are in an MTLSS plan in an aligned MA plan. We support re-activating this process in this more-limited form. In addition, we propose that:

- CMS either reinstate organizations which have already received approval for the seamless conversion process or prioritize their reauthorization in order to minimize the administrative burden of reapplying;
- CMS consider plans with dually eligible members enrolled in their non-aligned D-SNP and/or MLTSS products to seamlessly convert them to their MMPs under the same rules;
- CMS permit states with an existing Medicare-Medicaid Plan (MMP), which choose to implement the more limited default enrollment process, to use passive enrollment as a priority over seamless conversion, at the state's discretion;
- CMS issue clear guidance about the respective roles of States and plans in the enrollment process, including communication protocols; and
- CMS issue guidance on sample criteria that states may use in determining whether their Medicaid managed care plans and MA plans can use the default enrollment process. Such guidance provides a level of transparency, and it also helps ensure that a uniform and non-discriminatory process is being used.

***Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dually Eligible Beneficiaries (§422.60(g))***

CMS is proposing to expand its regulatory authority to passively enroll dually-eligible individuals in an MA plan to situations where "integrated care coverage would otherwise be disrupted." CMS provides two examples for this expanded authority: instances in which state re-procurement of a Medicaid managed care contract would disrupt an individual's coverage through a D-SNP and situations in which a D-SNP contract is not renewed. In these instances, the individual would be passively enrolled into an MA plan that operates a FIDE-SNP or meets the integration standard for a "highly integrated D-SNP." In addition, the plan must have a minimum overall MA Star Rating of at least 3 stars.

The passive enrollment authority would only exist where all four of the following conditions are met: (1) passive enrollment is necessary in order to promote integrated care and continuity of care, (2) such

action is taken in consultation with the state Medicaid agency, (3) the D-SNP receiving passive enrollment contracts with the state Medicaid agency to provide Medicaid services; and (4) "certain other conditions are met to promote continuity and quality of care."

The Association supports this expansion of authority for passive enrollment. In the proposed rule, CMS notes that it is considering limiting this expanded authority to those circumstances in which its exercise would not raise total cost to the Medicare and Medicaid programs. We do not see the value of imposing this kind of limitation on this expansion of authority. For one, we believe there are few circumstances that might cause the transfer of beneficiaries from one integrated plan to another to substantially raise total Medicare and Medicaid costs. In addition, the added cost and administrative burden in identifying these circumstances and measuring the cost effects would potentially offset any value.

***Establishing Limitations for the Part D Special Election Period (SEP) for Dually Eligible Beneficiaries (§423.38)***

Dual eligible and other subsidy-eligible beneficiaries have access to a Special Enrollment Period (SEP) that allows eligible beneficiaries to make Part D enrollment changes throughout the year. As CMS notes in the proposed rule, this provision related to Part D benefits has unintended effects for integrated plans that cover a full range of services and supports for dual eligible beneficiaries. In particular, the ability to repeatedly enroll and disenroll in plans interferes with plans efforts to coordinate and manage care and provide seamless, continuous coverage through the integration of Medicare and Medicaid benefits.

CMS proposes to amend the SEP to limit its availability to (1) eligible beneficiaries who meet the definition of an at-risk beneficiary or potential at-risk beneficiary who would be able to use the SEP once per calendar year, (2) beneficiaries who have been assigned to a plan by CMS or a State who would be able to use the SEP before that election becomes effective or within 2 months of their enrollment in that plan or (3) dual and other low income subsidy (LIS)-eligible beneficiaries who have a change in their Medicaid or LIS-eligible status would have an SEP to make an election within 2 months of the change, or of being notified of such change.

The Association supports reasonable restrictions on the use of multiple enrollment changes in order to promote stability and continuity of coverage for dual-eligible enrollees. Continuity of coverage is critical if beneficiaries are to realize the full benefits of an integrated plan. To that end, we encourage CMS to include MMPs in the SEP provision, rather than limiting the proposed rule to only PDP and MA-PD plans.

At the same time, beneficiaries should always be able to make a choice of coverage that best serves their needs. To avoid disincentivizing dual-eligible beneficiaries from enrolling in integrated MA-PD plans, SEPs should not be limited for enrollees transitioning to integrated plans. Further, dual-eligible members with disabilities should retain the option to switch between comparably aligned and integrated products if their key disability- or LTSS-related providers, prescriptions, or DME are no longer covered by their current plan. We believe this revision in the SEP strikes the appropriate balance between the exercise of informed choice and continuity and stability in coverage necessary to promote coordinated care.

We appreciate this opportunity to provide comment on the proposed rule. We believe all of the proposals we discuss above will encourage expansion of integrated plans and improve their value to beneficiaries. Coordination of care across medical and non-medical sectors is critical to success in

managing the quality of care, creating a seamless care experience for the individual and family, and managing spending effectively for states and the federal government.

We welcome the opportunity to meet with members of CMS to discuss our comments or the efforts of the Association. If you have any questions, please contact me at latkins@mltss.org.

Sincerely,

G. Lawrence Atkins
Executive Director