National
MLTSS
Health Plan Association

December 19, 2018

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

RE: CY2020-2021 Proposed Policy and Technical Changes to the Medicare Advantage Program
CMS-4185-P

Dear Administrator Verma:

Thank you for the opportunity to provide comment on the Centers for Medicare and Medicaid Services' proposed rule *Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021.*

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 Plans Inc.

As outlined in the proposed rule, section 50311(b) of *The Bipartisan Budget Act (BBA) of 2018* (PL 115-123) permanently authorized all forms of Medicare Advantage Special Needs Plans (SNPs), required the Secretary of the Department of Health and Human Services to develop an aligned grievances and appeals process for dual-eligible SNPs (D-SNPs) ("to the extent feasible") by April 1, 2020, and required that all D-SNPs meet one or more of a set of integration requirements put forth in the legislation ("to the extent permitted under State law") by 2021 and subsequent years. As we've expressed before, this legislation is key to advancing models that fully integrate Medicare and Medicaid benefits by working to align coverage for people eligible for both programs.

The Association believes that all dual eligible beneficiaries should have the opportunity to be enrolled in a plan that integrates Medicare and Medicaid coverage. The Association supports the intent of the statutory provisions in the BBA to establish clear requirements for D-SNPs to move toward integration with Medicaid MLTSS plans and state Medicaid programs generally, to encourage more rapid adoption of integrated models, and promote more widespread enrollment in integrated plans of the population that is eligible for both Medicare and Medicaid coverage.

The Association also supports the provisions of the Act that provide minimum criteria for integration with state Medicaid programs that D-SNPs would be expected to meet by a date certain. At the same time, we support the interpretation provided in the proposed rule that would allow states with traditional Medicaid programs (without MLTSS plans) and D-SNPs operating in those states to make a gradual transition to greater integration while minimizing the impact of this transition on dual-eligible individuals. With respect to the limited implementation of a unified grievances and appeals process, we are concerned with CMS's proposed prohibition on the ability of an applicable integrated plan to recover the costs of services provided during a pending appeal and its impact on plan operations.

Below we offer comments on the various proposals as they appear in each subsection of the proposed rule.

Definitions of a ''Dual Eligible Special Needs Plan'', ''Fully Integrated Dual Eligible Special Needs Plan'', ''Highly Integrated Dual Eligible Special Needs Plan'', and ''Aligned Enrollment'' (§ 422.2)

In response to the BBA of 2018, CMS proposes three categories of changes related to the definitions and phrases that refer to various forms of D-SNPs and enrollment in these plans:

- Changes to the existing definitions of D-SNP and FIDE-SNP and the creation of a new form of integrated plan: a "highly integrated dual-eligible special needs plan (HIDE-SNP)",
- Changes to the interpretation of the existing phrase "arrange for benefits" that is part of the definition of a D-SNP, and
- Creation of the terms "aligned enrollment" and "exclusively aligned enrollment" that differentiate the extent of alignment between the population enrolled in an organization's MLTSS plan and the population enrolled in that organization's D-SNP.

I. Definitions of D-SNP, HIDE-SNP, and FIDE-SNP

For the definitions of D-SNP and FIDE-SNP, CMS's proposed changes incorporate three newly specified levels of integration that operate as steps toward full integration – one of which every extant D-SNP must meet by 2021.

The lowest level of integration applies to a D-SNP operating in a state without an MLTSS or managed behavioral health contract, where the integration would occur through arrangements the plan would make with the state's "fee-for-service" Medicaid program to ensure coordination of the delivery of Medicare and Medicaid benefits.

The proposed rules then create a new category of integrated SNP, termed a HIDE-SNP, that would define the next level or step-up of integration. This is a "D-SNP offered by a MA organization that has…a capitated contract with the Medicaid agency in the state in which the D-SNP operates that includes coverage of LTSS [and/or] behavioral health services…" The HIDE-SNP is two separate plans (a SNP and an MLTSS plan) operated by the same organization that enrolls members separately but strives to enroll the same members in both plans to integrate the resources and the care experience for the beneficiary.

The highest level of integration is found in the existing Fully-Integrated, Dual-Eligible Special Needs Plan (FIDE-SNP), which combines the full spectrum of available Medicare and Medicaid managed care benefits. For the purposes of enrollment, care coordination, and other administrative tasks, it operates as a single plan.

The Association supports efforts to encourage states to move toward a more integrated and seamless system of care for dual-eligible beneficiaries and eventually for all individuals with LTSS needs. In keeping with this, the Association supports the definitions of these three models that serve as steps toward full integration for states, and that start at a level of integration that can work in states that do not now have managed LTSS and/or managed behavioral health.

It is important to allow for plans that have been operating D-SNPs in states without MLTSS or operating without an MLTSS contract in states that have MLTSS to gradually make the transition to greater integration and eventually full integration. For this reason, the Association supports, in states that have HIDE-SNPs, allowing the continued operation of D-SNPs that do not have an aligned MLTSS plan as a transition to a more highly- or fully-integrated model. The Association also supports allowing D-SNPs in states that have carved out behavioral health or LTSS to align enrollment with a Medicaid managed care plan that excludes the carved-out benefits, "consistent with state policy".

We recognize the need to create a definition for a less-than-fully-integrated model of integrated plan (a HIDE-SNP) – one in which a D-SNP pairs with a corresponding MLTSS plan and/or managed behavioral health operated by the same organization, enabling enrollees separately enrolled in each of the plans to be aligned. At the same time, though, we regret the need to add to an already-confusing panoply of integrated plan types yet another acronym for a different type of integrated plan.

We urge CMS to continue to work toward a unified regulatory framework that would apply to all types of integrated Medicare and Medicaid plans in the future. While such a framework may preserve some of the appropriately unique features of individual "modalities" (e.g., MMP, PACE, FIDE-SNP), features that do not need to vary should be uniform across all modalities. In addition to uniform appeals and grievance procedures that are addressed in this proposed rule, a common framework should include uniform rules on marketing, enrollment processes, claims reporting, rate-setting, and risk adjustment.

Ultimately, a single statutory-regulatory structure should apply to "integrated plans" and all dual-eligible individuals should be enrolled in such plans, with the ability to enroll in their preferred plan (i.e. dual-eligible individuals should not be enrolled in a FFS environment or an unaligned managed environment, including "look-alike" MA plans). An "integrated plan" should have the capacity to combine coverage for medical care, behavioral health, and LTSS benefits in a single organization that receives capitated Medicare and Medicare payments and operates for individuals with complex care needs with all of the essential elements of a managed, coordinated care experience, including comprehensive assessment, person-centered care planning, care management, interdisciplinary care teams, and coverage for services determined appropriate by the plan. This would be an organization that is accountable for enrollee health outcomes, satisfaction, and quality of life.

II. Interpretation of the existing phrase "arrange for benefits"

CMS includes discussion around its proposed interpretation of the existing phrase "arrange for benefits". CMS proposes to establish an "affirmative duty" for all D-SNPs to arrange for Medicaid benefits for enrolled beneficiaries. CMS explains that "for all enrollees who are eligible for Medicaid services, the D–SNP must fulfill its statutory responsibility to arrange for the provision of Medicaid benefits by facilitating a beneficiary's meaningful access to such benefits." D-SNPs that identify enrollees with functional limitations or mental health needs will be required to very their eligibility for Medicaid LTSS and/or behavioral health services and make arrangements with the Medicaid program for provision of the

services. D-SNPs could not simply direct a beneficiary to contact a Medicaid agency without, at a minimum providing specific contact information, coaching on the roles of the Medicaid program, and offering additional support if needed.

The Association supports the minimal requirement that all D-SNPs have an affirmative duty to ensure that all their full dual-eligible enrollees in need of behavioral health services and/or LTSS receive these services (if they qualify) through a state Medicaid agency or a Medicaid managed care plan. We believe this requirement should not be met simply by sending enrollees in search of Medicaid benefits, but should include a requirement that the plan obtain confirmation from the state agency or plan that the enrollee is covered.

We would also ask CMS to clarify the expectations it has set out for D-SNPs as they "arrange for benefits." CMS first provides examples of the "wide range of activities a D-SNP may engage in for their dual eligible members." CMS subsequently lists some activities it believes would be "insufficient" for a D-SNP to engage in (i.e. "simply telling a beneficiary to call or write their Medicaid managed care plan or state agency"). However, it then lists activities that would possibly rectify the "insufficient" behavior (i.e. "giving specific contact information, giving specific coaching on the roles of the Medicaid program, and offering additional support if needed."). We are concerned that certain D-SNPs may interpret the rectifying activities as constituting an acceptable level of activity to meet the requirements for "arranging for benefits" and may do nothing to confirm that their dual eligible members are actually enrolled in Medicaid. We recommend that CMS clarify that the first list of actions is the minimum level of activity necessary to meet the standard for "arranging for benefits", and that D-SNPs have a duty to confirm that members are enrolled in Medicaid and able to receive Medicaid benefits.

III. Definitions for "aligned enrollment" and "exclusively aligned enrollment"

The term "aligned enrollment" is proposed to refer to when "a full-benefit, dual-eligible individual is a member of a D–SNP and receives coverage of Medicaid benefits from a Medicaid managed care organization that is: (1) The same organization as the MA organization offering the D–SNP; (2) its parent organization; or (3) another entity that is owned and controlled by the D–SNP's parent organization." The term "exclusively aligned enrollment" is proposed to refer to situations in which it is state policy to limit a D-SNP's membership to individuals with aligned enrollment. We believe these two terms adequately capture the current nature of enrollment across all D-SNPs and agree with how CMS applies them in its new unified grievances and appeals proposals.

IV. Interpretation of the phrase "consistent with state policy"

Separate from the proposals related to definitions for D-SNPs and enrollment, CMS includes discussion of its interpretation of the phrase "consistent with state policy" that appears in the statutory language of the BBA. CMS states this phrase permits it to accommodate certain service or population carve-outs in response to state policy, except for where specifically prohibited, and to allow for "multiple avenues" for D-SNPs to satisfy these new requirements. However, CMS considered an alternative interpretation to mean that "in states that have Medicaid managed care programs for dual eligible individuals, all MA organizations seeking to offer a D-SNP could do so only if they were under contract with the state to offer a companion Medicaid managed care plan in that state, because such an opportunity is permitted under state law."

The Association believes the language "consistent with state policy" was included in the BBA to allow D-SNPs to continue to operate where state policy makes it difficult to highly- or fully-integrate. This may be because state policy either carves out populations or services, or limits availability of managed Medicaid plans by not expanding MLTSS statewide or providing sufficient MLTSS contracts. The interpretation CMS has placed on this phrase in the proposed rule allows for unaligned D-SNPs to continue in states that have not acted to remove barriers to integration on the Medicaid side. Medicare rules should not override state policy where policy has intentionally or unintentionally prevented full integration. Rather, CMS should accept integration where it can exist and incent the states to move state policy toward a Medicaid program that can align with more-integrated models. Ultimately, states should be encouraged to adopt, at a minimum, a model of aligned integration, such as a HIDE-SNP, with any form of Medicaid managed care, such as MLTSS or managed behavioral health. This would ensure that all beneficiaries in a state have consistent access to aligned integration and that aligned D-SNPs have the capacity to address their beneficiaries' functional and behavioral health needs.

Dual Eligible Special Needs Plans and Contracts With States (§ 422.107)

As proposed, any D-SNP that is not a FIDE-SNP or HIDE-SNP would be subject to a minimum contracting requirement to notify a state Medicaid agency (or its designee) whenever a dual-eligible beneficiary belonging to at least one "high-risk" group (defined by the state) is admitted to a hospital or skilled nursing facility (SNF). As stated, the purpose of this requirement is to "promote successful transitions of care into a setting of the beneficiary's choice, and increase coordination among those involved in furnishing and paying for primary care, acute care, LTSS, and behavioral health services." CMS notes that it considered several alternative requirements that varied by how prescriptive and expansive they are relative to the proposed requirement.

This approach is truly a minimum that should be expected to meet a threshold for integration. While this proposed requirement can act as a "catalyst" for a more meaningful level of integration across clinical settings, data systems, and administrative structures, it does not ensure that level of integration develops. The flexibility afforded to states in establishing the structure and process for these notifications creates the potential for innovative approaches to track beneficiaries as they move through the health care system and ensure their needs are met at various care transition points, when beneficiaries are more likely to need additional support. To help realize this potential, we encourage CMS to provide technical assistance and information on "best practices" to assist states in developing technologies and administrative systems that are needed to ensure a sufficient degree of coordination is achieved through this approach to promote successful transitions of care.

Regarding the alternatives CMS considered for the proposed minimum contracting requirement, we agree with the general themes of reducing administrative and scheduling barriers that may impede coordinated care, enabling the exchange of data between state and provider partners, and ensuring providers are aware of the covered services available to their patients. We would support incorporating some of these additional features in the minimum contracting requirement, with the understanding that CMS would allow stakeholders to implement and evaluate the impact of the proposed hospital/SNF admission notification system as a starting point before adding additional requirements.

Eligibility of Partial-Benefit Dual Eligible Individuals for Dual Eligible Special Needs Plans

Partial dual eligible beneficiaries are Medicare beneficiaries for whom Medicaid pays Medicare cost sharing but does not provide benefits beyond those covered under Medicare. Coordination of Medicaid with Medicare is solely around payment and not coverage or service delivery. As a result, there is no coordination or integration of Medicare and Medicaid benefits to be achieved. Partial dual beneficiaries may realize great value from the way Medicare-covered services are provided and coordinated in a SNP that focuses on complex care populations, but are not served by the coordination and integration with Medicaid benefits that is implicit in the concept of a D-SNP. There are challenges in achieving an integrated result for a plan population where there is little programmatic overlap between partial benefit and full benefit dual-eligible individuals. This argues for enrollment of partial dual eligibles in a form of SNP that is not primarily focused on integrating Medicare and Medicaid benefits, but does have a greater level of experience in caring for complex populations relative to a traditional Medicare Advantage (MA) plan.

Unified Grievance and Appeals Procedures for Dual Eligible Special Needs Plans and Medicaid Managed Care Plans at the Plan Level (§§ 422.560–562, 422.566, 422.629–634, 438.210, 438.400, and 438.402)

CMS proposes to require all D-SNPs to assist beneficiaries (if asked or when made aware of a need) with Medicaid coverage issues and grievances, including assistance with the actual filing of grievances, requesting coverage, assembling medical documentation with the aid of a care coordinator, and requesting appeals. CMS notes that a D-SNP would not be obligated to represent the enrollee in Medicaid appeals nor would they expect every enrollee to need or want an extensive amount of support with these processes.

We agree with the principle that D-SNPs should holistically assist beneficiaries in the process of coordinating their care, which would include accessing and appealing for services. Stakeholders across the health care spectrum recognize the complexity and difficulty of navigating an appeals and grievances process for both Medicare and Medicaid, which is only made more difficult when beneficiaries lack access to resources, social support systems, and/or have functional impairments. We recognize the role health plans play in the process and that we and others have the information and expertise available to assist beneficiaries. However, we would like to stress the equally important role that state managed care ombudsman play in this process. As independent third-parties, their infrastructure should be leveraged to support beneficiaries in complement with other efforts.

CMS additionally states that it does not believe it is feasible currently to implement a fully unified grievance and appeals systems for D-SNPs and Medicaid managed care plans that do not have the same enrollees. Therefore, only HIDE-SNPs and FIDE-SNPs with exclusively aligned enrollment would be subject to several requirements for a more unified grievances and appeals process. These changes include the statutory requirement for CMS to adopt a continuation of benefits pending appeal policy for both Medicaid and Medicare benefits. CMS further proposes to prohibit plans from recovering the cost of services provided during the reconsideration.

We understand the benefit and rationale related to CMS's proposal to implement a continuation of services pending appeals process, but we are concerned with the proposal that would change current Medicare policy to disallow plans from recovering the cost of services provided pending appeal. While this change would currently affect only a small portion of plans overall, it would represent a significant change

in benefit policy for those plans and could possibly have major financial implications. Therefore, we ask that CMS closely monitor this as an issue and make appropriate changes if needed to minimize the added financial impact on these applicable plans in the future.

Other Considerations

We would like to take this opportunity to reaffirm our support for the Medicare-Medicaid Plans (MMPs) launched under the Financial Alignment Initiative (FAI). As Congress and CMS pursue a greater level of integration for dual-eligible beneficiaries, we believe it is key to maintain the programs' operations due to their success and the lessons they have and will provide. As the stakeholder community continues to explore and refine its approach to effective integration, the MMPs represent a significant investment and commitment by the stakeholder community to an effective form of integration. We urge CMS to seek to make these programs permanent and to begin considering how it can encourage wider adoption of MMPs, based on the lessons learned to date by the demonstration. In addition, the elements of the MMP model that contribute to its success should be viewed as a starting point for a common statutory and regulatory framework for all forms of integrated plans.

Separately, we ask that CMS distribute any necessary guidance on how the changes proposed may affect the operations of the MMP programs.

We would like to additionally reiterate the need to develop a risk adjustment model that adequately accounts for the costs of caring for beneficiaries with functional limitations. A recent report from the Government Accountability Office (GAO) concluded that the current hierarchical condition categories (HCC) risk adjustment system for Medicare Advantage (MA) underestimates spending for individuals with functional limitations (i.e. the ability to perform activities of daily living (ADLs), such as dressing or bathing) and overestimates spending for those without functional limitations.[1] Without adequate adjustment in payment for functional limitations, plans that attract and serve persons with disabilities and other complex care needs face a financial penalty and adverse selection risk. More importantly, there is a risk that this payment imbalance may result in individuals with disabilities not being afforded the same access to Medicare Advantage as other beneficiaries.

Conclusion

The Association supports the SNP reauthorization and integration provisions in the BBA and this proposed rule as an important step forward in advancing a coordinated and integrated delivery system for our members with the most complex care needs. More importantly it sets in place clear stepping stones that states and plans that have not adopted fully integrated models for dual-eligible beneficiaries can follow in moving toward integration. Integration of 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 for Americans with complex care needs. As early evaluation results from the Financial Alignment Demonstration are beginning to show, integration of medical care, behavioral health, and LTSS can 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.

[1] Government Accountability Office. (2018) *Medicare Advantage: Benefits and Challenges of Payment Adjustments Based on Beneficiaries' Ability to Perform Daily Tasks (GAO-18-588).*

We welcome the opportunity to meet with your staff 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