National
MLTSS
Health Plan Association

February 27, 2019

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

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter [CMS-2018-0154]

Dear Administrator Verma:

Thank you for the opportunity to provide comment on the Centers for Medicare and Medicaid Services' proposals via the *Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Draft Call Letter.*

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 offer MLTSS plans in nearly all states with Medicaid MLTSS, and assist those 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, CareSource, Centene Corp., Commonwealth Care Alliance, Health Plan of San Mateo, L.A. Care Health Plan, Tufts Health Plan, UPMC Health Plan, VNSNY CHOICE, and WellCare Health Plans Inc.

As outlined in certain sections of the Call Letter, CMS continues to focus on the issues affecting the integration of Medicare and Medicaid benefits for dual-eligible individuals, especially as they relate to dual-eligible special needs plans (D-SNPs). We appreciate CMS's continued commitment to pursuing a greater level of integration for all dually-eligible beneficiaries, especially as it relates to the alignment of administrative regulations, the subject of D-SNP "look-alikes", and reducing the administrative burden associated with a lack of an automated claims crossover process for dual-eligible individuals served by Medicare Advantage (MA).

Below we offer specific comments on the issues raised above and our suggestions on ways in which CMS could proceed to further advance integration.

D-SNP Administrative Alignment Opportunities

We appreciate CMS's efforts to "provide administrative flexibility that facilitates efforts by state Medicaid agencies and MA organizations to use D-SNPs to integrate coverage of Medicaid and Medicare coverage." Recent policies such as allowing D-SNPs to use default enrollment for newly Medicare-eligible individuals into an integrated D-SNP and the alignment of grievances and appeals for highly-integrated D-SNPs (HIDE-SNPs) and FIDE-SNPs with exclusively aligned enrollment both move toward the goal of achieving integration for all dual-eligible beneficiaries.

The Association, however, questions that default enrollment or passive enrollment should be made available to states only in limited circumstances, such as when dual beneficiaries enrolled in Medicaid first become eligible for Medicare. If aligned enrollment results in better coordination of coverage and services, then, in states with integrated plans available, all dual eligible beneficiaries should have choice among and enroll in integrated plans. "Duals" should not be vulnerable to marketing by MA plans that do not meet D-SNP requirements for provision of care and alignment with Medicaid.

On the subject of other administrative alignment opportunities that should be available for D-SNPs, the Association recommends that CMS follow on the effort to align appeals and grievance procedures in integrated plans with a more ambitious effort to develop a common Medicare-Medicaid regulatory framework that would apply to all forms of integrated plans. Ultimately, a single regulatory structure should apply to all forms of D-SNPs, MMPs, and PACE, given that they serve a common population of dual-eligible individuals, despite some variation in enrollment related to level of need or clinical factors. We recognize that each of these programs has features and clinical models that are unique, some of which may provide a distinct benefit to the beneficiaries they serve. A single regulatory framework could accommodate a range of modalities that would preserve these features. In the end, though, it should establish a level playing field between various types of integrated plans and eliminate current payment and regulatory incentives to choose one model over another.

The Association recommends that CMS develop an improved version of the MMP that incorporates learnings from the Financial Alignment Initiative (FAI) and recommendations from this and other health plan associations. The revised MMP would be the basis for the common framework. States that have participated in the FAI could transition to the new model. CMS would encourage other states with integrated models to adopt the new MMP or make revisions to their existing models that would improve their alignment with the common framework.

D-SNP "Look-alikes"

CMS notes it has "seen bids for an increasing number of MA plans with plan benefit packages similar to those of current DSNP look-alikes." These plans, referred to as "look-alikes", employ "misleading

marketing and broker training techniques" largely focused on dual-eligible beneficiaries. CMS further states that these look-alike plans "may undermine state efforts to integrate Medicare and Medicaid benefits through their contracted D-SNPs or MMPs."

The Association notes that the MA-only "look alike" plans seek to market to dual beneficiaries when states permit this activity in areas already served by integrated D-SNPs (HIDE-SNPs or FIDE-SNPs) and/or Medicare-Medicaid plans (MMPs). The MA-only plans draw enrollees away from highly- and fully-integrated plans that would better serve their full range of dual eligibles' health care, behavioral health, and LTSS needs, while receiving the higher payment rate associated with serving the greater needs of dual eliglbles. The Association believes dual eligible beneficiaries are better served in an integrated plan, and so, in areas with highly- or fully-integrated plan options, they should have a choice among these available integrated modalities. Given that the competing non-integrated "look-alike" MA plans do not meet D-SNP requirements for assessments, care plans, or having a CMS-approved model of care, or for coordinating with Medicaid benefits, either through an aligned Medicaid plan or a contract with a state Medicaid agency, these so called "look-alike" plans should not be allowed to market to or enroll dual-eligible beneficiaries in an area served by integrated plans. We look forward to future rulemaking CMS may use to address this issue and will look for any additional guidance CMS may provide in the meantime.

The Association further notes that in many states insurance brokers have incentives to direct dual eligible benefits to MA plans that provide better commissions than the integrated plans are able to. We recommend that CMS investigate alternatives that would eliminate the differential in broker commissions and any other incentives that may encourage brokers to direct dual eligible beneficiaries away from enrolling in integrated plans.

Medicare Advantage Organizations Crossing Claims over to Medicaid Agencies

As outlined in the Call Letter, a provision in the 2016 Medicaid Managed Care Final Rule requires the inclusion of language in state Medicaid contracts with health plans serving dual beneficiaries to enter into a Coordination of Benefits Agreement (COBA) and participate in an automated crossover claim process to eliminate the need for providers to submit separate claims to the Medicare and Medicaid managed care organizations. However, there is no similar requirement for MA organizations. As we stated in our previously submitted comments on changes in the Medicaid managed care regulations, a COBA only provides access to a member's Medicare FFS claims data. It does not provide access to FFS clinical or chart data. Medicaid plans serving an unaligned Dual must request specific data from the other plan (or from the FFS entity in the case of clinical data). This often results in substantial delays in obtaining the needed data.

The Association supports CMS's effort to improve crossover claims between Medicare and Medicaid entities and recommends that CMS provide state Medicaid agencies more guidance in developing crossover claims approaches that will enable automation that will include Medicare managed care organizations.

Changes in the Part C Payment Methodology – CMS-HCC Risk Adjustment Model for PACE Organizations, and the Frailty Adjustment for PACE Organizations and FIDE-SNPs.

CMS proposes changes to the Part C risk adjustment model for CY 2020 that would include incorporating additional HCC categories to better characterize high-risk members and improve the predictive power of the HCC model for a population with a high concentration of these members. CMS further proposes using the 2017 CMS-HCC model for risk adjustments for PACE organizations rather than a separate PACE model, and using frailty factors associated with this model.

The Association supports CMS's efforts to improve the risk adjustment methodology for MA plans to move beyond diagnoses and to better reflect the complex care needs and higher costs of members with functional limitations. These changes to the CMS-HCC model and the application of the CMS-HCC model to PACE organizations and updated frailty factors for PACE and FIDE-SNPs would bring risk adjustment for these plans more in line with other MA plans.

The Association believes that different models of integrated care (e.g., MMP, FIDE-SNP, PACE) that serve populations with similar complex care needs should have consistent risk adjustment that adequately accounts for the functional needs of the population. Providing a common approach to risk adjustment across all types of integrated plans would reduce the financial incentives that favor one type of integrated plan over another.

Conclusion

We appreciate CMS's continued efforts to advance integration for D-SNPs and across all other integrated modalities. The 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 the evaluation results from the Financial Alignment Demonstration show, integration of medical care, behavioral health, and LTSS can ensure 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.

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