



January 16, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4182-P
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically via <https://www.regulations.gov/>

Re: CMS-4182-P: Medicare Program; 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 Proposed Rule

Dear Administrator Verma,

Medicaid Health Plans of America (MHPA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid's (CMS) proposed regulation entitled "Medicare Program; 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" published in the Federal Register on November 28, 2017. MHPA applauds CMS' efforts to strengthen these important programs as well as the Agency's continued efforts to ensure access to comprehensive care for vulnerable beneficiaries, especially beneficiaries that are covered under both the Medicare and Medicaid program, known as dual eligible beneficiaries.

MHPA is the national trade association representing 126 private-sector health plans that contract with state Medicaid agencies in 34 states plus DC to provide comprehensive, high-quality health care to more than 24 million Medicaid enrollees in a coordinated and cost-effective way. According to a recent analysis by PWC, 73 percent of all Medicaid enrollees received their care through a private Medicaid health plan in 2017 (up from 66 percent in 2014),¹ this number continues to rise annually as more states turn to the expertise of managed care plans to help manage health care for a growing number of Medicaid enrollees with diverse needs.

For the over 11 million dual eligible Medicare beneficiaries, Medicaid plays a critical part in their full health coverage. Many MHPA plans serve dual eligible beneficiaries in some capacity and have long led efforts to improve care and benefit coordination for this population. As part of this, a number of MHPA's plans have diversified into the Medicare Advantage (MA) space, particularly as dual eligible special needs plans (D-SNPs) to act in a broader, more comprehensive role in serving this population.

¹ Gottlieb, Ari, *The Complicated State of Medicaid in the United States: Stability Amidst Considerable Future Uncertainty*, PWC, October 2017.

Overall, MHPA appreciates the Agency's direction with the proposed regulation in offering plans greater flexibility to innovate and drive improvements in care for beneficiaries. Our member plans have extensive experience providing high-quality, comprehensive care to high-cost, high-need populations such as the dual eligible population, and we believe that we can be effective partners in helping to transform care for these beneficiaries.

Our specific comments primarily focus on proposals impacting dual eligible beneficiaries but we also include some high-level comments on select other proposals.

The following proposals are addressed in these comments:

- **Proposals Impacting Coverage for Dual Eligible Beneficiaries**
 - Establishing limitations for the Part D Special Enrollment Periods (SEPs) for low-income subsidy eligible and dual eligible beneficiaries
 - Seamless conversion of Medicaid beneficiaries into dual eligible special needs plans (D-SNPs) offered by the same organization
 - Passive enrollment flexibilities to protect continuity of integrated care for dually eligible beneficiaries
- **Other Proposed Changes**
 - Codification of the Star Ratings Processes and Continued Need for Socio-Economic Status Adjustments to the Star Ratings
 - Changes to the Medical Loss Ratio Requirements (MLR)

Comments on Proposals Impacting Coverage for Dual Eligible Beneficiaries

MHPA Supports the Proposed Changes to the Special Enrollment Periods (SEPs) for Dual Eligible Beneficiaries, Including the Limitation on SEPs for “At-Risk” Beneficiaries

MHPA plans support CMS' proposals to make changes to the current Special Enrollment Periods (SEPs) for dual eligible beneficiaries, including the creation of a new SEP for this population. We believe these proposals strike the right balance between ensuring continuity of care for this population and offering the ability for dual eligible beneficiaries to change coverage when required to meet their needs, especially when a beneficiary is auto-enrolled in a plan. Additionally, we support CMS' goal of reducing complexity for this population and providing better coordination with states by bringing the Medicare and Medicaid “enrollment policies into greater alignment.”

In the proposed regulation, CMS seeks to make changes to the continuous enrollment opportunity available at §423.38(c)(4) which allows current dual eligible and low-income subsidy eligible beneficiaries to change their Part D plan coverage (including MA plans with Part D) monthly. Specifically, CMS outlines a proposal to make changes to the continuous enrollment SEP for this population to three instances which includes the creation of a new SEP opportunity.

CMS would allow eligible beneficiaries to have a one-time per year SEP to change coverage. CMS would also permit beneficiaries that are auto-enrolled by either the State or CMS into coverage to have an opportunity to change before or within 2 months of coverage effectuation. Finally, CMS would create a new SEP opportunity to allow beneficiaries with a change in Medicaid status or level, an opportunity to change their coverage within two months of the change in Medicaid eligibility or financial status. Since dual eligible beneficiaries in MA plans are permitted the same continuous SEP opportunity currently, CMS proposes to make changes

through sub regulatory guidance to align the MA SEP provisions for dual eligible beneficiaries with the Part D provisions.

MHPA agrees with CMS that, while important to maintain ability for dual eligible beneficiaries to engage in active coverage choices, there are obstacles to improving coverage and care when these beneficiaries switch plans too frequently. It is our plans' experience that some of the most important activities for disease management and better coordination of care and services for this population require the beneficiary to remain with the plan for a period of time and that frequent switching of plans can undermine important aspects of delivering higher quality integrated care for this population. Therefore, MHPA supports CMS' proposal for more limited SEP opportunities, including allowing an annual SEP opportunity, a separate SEP for auto-enrolled beneficiaries and the new SEP for changes in Medicaid status.

MHPA also specifically supports CMS' proposal to create a new SEP for dual and other LIS-eligible beneficiaries who have a change in their Medicaid or LIS-eligible status, allowing beneficiaries to elect new coverage within 2 months of the change, or of being notified of such change, whichever is later. We agree that these types of changes to assistance could create a more meaningful need for beneficiaries to consider different coverage. Finally, while we generally support the idea that this SEP should still be available to "at-risk" beneficiaries or "potential at-risk" beneficiaries, we suggest that CMS monitor the use of SEPs to ensure that even under these limited circumstances, they are not being abused.

Beyond these SEPs, dual eligible beneficiaries would still be able to make plan choices during annual enrollment periods as well as for more traditional SEP triggering events available for all beneficiaries such as change of permanent residence. We believe that by considering circumstances triggering these SEPs as "separate and unique" from each other and allowing beneficiaries to use each of these as needed throughout the year, the Agency has protected the ability of beneficiaries to actively make their coverage decisions when truly needed without undermining other important objectives in improving care for this population.

Limiting SEPs for "At-Risk" and "Potentially At-Risk" Beneficiaries: Under the implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA) regulations, CMS also proposes to limit SEPs for "at-risk" or "potential at-risk" beneficiaries, and these limitations would apply to the one-time, annual SEP that CMS proposes as well as to a SEP following auto-enrollment. The limitation would not apply to the proposed new SEP as CMS believes that with a change of Medicaid status or financial level, a beneficiary may have unique reasons to seek new plan coverage.

MHPA also supports CMS' proposal to limit SEPs for beneficiaries that are "at-risk" or "potentially at-risk" of abusing certain drugs including opioids. We believe that this would allow clearer line of sight into patterns of abuse and prevent those that do abuse from frequent plan switching which currently creates a "loophole" for monitoring drug abuse.

MHPA Recommends that CMS Move Forward with Their Proposal to Allow Seamless Conversion of Medicaid Enrollees into D-SNPs

MHPA supports CMS' proposal to allow seamless default enrollments of dual eligible beneficiaries into D-SNPs upon conversion to Medicare. We believe this proposal promotes continuity of care and consistency of chronic condition and disease management programs for beneficiaries that are dual eligible. Further, our plans partner with a number of states and we

believe this proposal increases state options for encouraging enrollment into integrated products and allows states to specify conditions for this enrollment process.

MHPA plans also are generally supportive of the proposed conditions that plans will need to meet to be eligible for these seamless default enrollments. Specifically, CMS lists the following as necessary requirements for plans to receive seamless enrollments: (1) the individual is enrolled in an affiliated Medicaid managed care plan and is dually eligible for Medicare and Medicaid; (2) the state has approved use of this default enrollment process and provided Medicare eligibility information to the MA organization; (3) the individual does not opt out of the default enrollment; (4) the MA organization provides a notice that meets CMS requirements to the individual; and (5) CMS has approved the MA organization to use the default enrollment process before any enrollments are processed.

Our plans also believe that the beneficiary protections for this process as proposed will be strong. CMS has proposed changes to the notice requirements to beneficiaries to ensure that Medicaid beneficiaries are aware of the default MA enrollment and of the changes in coverage. Further the MA organization must issue a notice no fewer than 60 days before the default enrollment effective date to the enrollee. The proposed revised notice must include clear information on the D-SNP, as well as instructions to the individual on how to opt out of the default enrollment and how to enroll in Original Medicare or a different MA plan.

MHPA Generally Supports CMS' Proposal to Expand the Use of Passive Enrollment for Full Benefit Dual Eligible Beneficiaries in Certain Situations but Proposal Should Be Broadened

While we generally agree with CMS proposal to passively enroll full-benefit dually eligible beneficiaries who are currently enrolled in an integrated D-SNP into another integrated D-SNP under certain circumstances, we are concerned that the proposal to limit enrollment into only highly integrated or fully integrated D-SNPs (FIDE-SNPs) may limit the usefulness of this proposal. We are concerned that these more integrated plans are not as widely available and tend to operate in selected areas within a state. We think that there should be greater opportunity to enroll beneficiaries into the most integrated plan options available in these instances assuming the other conditions for passive enrollment are met.

CMS also seeks comment on limiting this proposal by requiring it not to raise Medicare and Medicaid costs. We are concerned that such a limitation may have unintended implications. While it will be difficult to measure cost differences between plans, we are concerned that these types of assessments might undervalue the long-term savings that better integration may offer beneficiaries overall or might limit the ability of plans to accept these beneficiaries.

Comments on Other Proposed Changes

MHPA Supports Codification of Most of Star Ratings Processes; However CMS Should Not Codify Categorical Adjustment Index and Should Continue to Explore Better Adjustments for Plans Serving a Disproportionate Share of Beneficiaries with Low Socio-Economic Status

MHPA applauds the Agency's decision to codify most of the current processes for quality measure selection and score development used in the MA and Part D Star Ratings. We agree that this will make the process more transparent and stable from year to year. Additionally, this

will allow plans sufficient time to better comment on and prepare for implementation of new measures and changes.

While we appreciate the Agency's efforts to strengthen the Star Ratings program by moving to a more transparent and stable process, we remain concerned that more needs to be done to address disparities in quality performance for plans that serve a disproportionate share of beneficiaries with low socio-economic status. As we have previously commented, there are numerous studies demonstrating the need to make adjustments to better account for differences in plan performance because of the underlying socio-demographics of the population served.² We also appreciate the work the Agency has done in implementing a temporary adjustment known as the categorical adjustment index (CAI), however, we continue to have concerns that this is not sufficient to alleviate the performance differences and is only considered an interim solution.

Further, since the CAI is an interim adjustment, MHPA recommends that CMS not codify the methodology for this process but maintain detailed and transparent information through the current sub-regulatory process. While we appreciate the agency's intent, we believe that the temporary purpose of this adjustment is best maintained in sub regulatory processes so that the agency may continue to more readily update as needed and move more quickly to more permanent solutions to address this issue.

In general, MHPA plans continue to seek a more permanent adjustment in the Star Ratings Program for plans serving a disproportionate share of beneficiaries with low SES, including but not limited to measure level risk adjustment where appropriate.

Finally, we wanted to take this opportunity to note that as the Agency moves forward with developing a Quality Rating System (QRS) for Medicaid managed care organizations, many of the considerations that apply to the Medicare Star Ratings program will likely have implications for, and interactions with, this new Medicaid QRS. We encourage the Agency to work with health plans to determine the best ways to align these quality programs where appropriate and improve evaluation and adjustment for the impact of social determinants of health on quality performance.

MHPA Supports Proposals on Including Fraud Reduction Activities in Medical Loss Ratio (MLR) and Should Align Medicaid MLR Requirements

CMS proposes to allow fraud reduction activities to be included in the calculation of the Medical Loss Ratio. We support this inclusion. We note that CMS should also consider aligning the policies on MLR for Medicaid managed care organization with this policy. CMS also proposes that MA and Part D plans only report the MLR percentage and amount of remittance owed to CMS. We also support this as it will reduce burden on the industry.

² See MHPA Response to CMS 2014 Request for Information — Data on Differences in Medicare Advantage (MA) and Part D Star Rating Quality Measurements for Dual-Eligible versus Non-Dual-Eligible Enrollees, November 3, 2014.

Thank you for the opportunity to comment on the proposed rule on changes to the MA and Part D programs for CY2019. We believe that this proposed rule advances a number of important program changes that would encourage innovations in care and promote integrated care options for dual eligible beneficiaries. We look forward to working with you to help implement these changes and welcome the opportunity for continued dialogue and collaboration with you in addressing the needs of vulnerable beneficiaries.

Sincerely,



Jeff Myers
President and CEO
Medicaid Health Plans of America