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January 12, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS–4182–P
P.O. Box 8013
Baltimore, MD 21244–8013

Re: **Comments on Proposed Rule: 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**

On behalf of the Massachusetts Executive Office of Health and Human Services (EOHHS), including the Massachusetts Medicaid program (MassHealth), Massachusetts greatly appreciates CMS's support of state efforts to promote enrollment in integrated care products, including, e.g. Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), Medicare-Medicaid Plans (MMPs), and other similar integrated models as may be developed and implemented in the future. As noted in the preamble of the Proposed Rule, beneficiaries dually eligible for Medicare and Medicaid (dual eligible beneficiaries) face significant challenges navigating the two programs and fragmentation between the two can result in a lack of coordinated care delivery, which may lead to unnecessary duplicative services and poor health outcomes for beneficiaries. Integrated products, such as FIDE SNPs and MMPs, offer a significant opportunity to improve quality, beneficiary satisfaction, care coordination, and reduce cost and administrative burden.

We are encouraged by some of the important first steps towards ensuring greater enrollment in, and sustainability of, integrated products in the Proposed Rule[1] published on November 28, 2017 and appreciate the opportunity to provide comments and offer additional suggestions to make progress toward our common goal of improving care for dual eligible beneficiaries.

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[1] https://www.gpo.gov/fdsys/pkg/FR-2017-11-28/pdf/2017-25068.pdf

Establishing Limitations on the Part D Special Election Period (SEP) for Dual Eligible Beneficiaries

Massachusetts supports CMS's proposal to modify the current Special Election Period (SEP) (42 CFR § 423.38(c)(4)) that is available to dual eligible and Low-Income Subsidy (LIS) beneficiaries from an open-ended monthly SEP to SEPs that are only available in specific circumstances. Aligning current SEP standards for dual eligible beneficiaries with other Medicare beneficiaries will improve the ability of plan sponsors to administer benefits, including better coordination of Medicare and Medicaid benefits, promote greater continuity of care, and provide greater opportunity to maximize care management and positive health outcomes.

To ensure that such limitations are balanced with maintaining beneficiary choice, we further support the addition of a new SEP for beneficiaries who experience a change in Medicaid or LIS eligibility status (42 CFR § 423.38(c)(9)). We also support the SEP for beneficiaries who have been assigned to a plan by CMS or a State (42 CFR § 423.38(c)(4)(ii)).

We also urge CMS to consider making the following changes and clarifications to its proposed rule:

- CMS should confirm that pursuant to 42 CFR § 422.773(c)(1), the proposed changes to SEPs apply to all full-benefit dual eligible beneficiaries.

- We urge CMS to consider extending all of the SEPs to 3 months for the purpose of alignment with the Medicaid Managed Care Rule finalized in May 2016. Specifically, the Medicaid Managed Care Rule describes enrollment choice periods of 90 days for voluntary managed care enrollments in 42 CFR § 438.56(c)(2)(i). As CMS notes, enrollment in integrated products, including highly integrated D-SNPs, FIDE SNPs, and MMPs has been increasing, and we strongly recommend alignment of Medicare and Medicaid enrollment rules and beneficiary protections as CMS considers updating the SEP process for dual eligible individuals. Without this alignment, it may be unclear whether the Medicare SEP or the broader Medicaid Managed Care Rule protections would apply for dual eligible individuals. For enhanced alignment with the Medicaid managed care rule, we also urge CMS to clarify that three months is equivalent to 90 days when calculating the beneficiary's enrollment choice periods under Medicaid and his or her SEPs under Medicare part D. This is especially important for Medicaid enrollment choice periods beginning in February, which, in most years, has only 28 days.

  In Massachusetts, a 90-day SEP would better align with continuity of care periods and requirements for care assessment and planning in our MMP, although we recognize that other demonstration states may be using different time periods for continuity of care and assessment completion. Massachusetts MMPs are required to conduct a comprehensive assessment of member care needs and create a comprehensive care plan within the first 90 days of a beneficiary's enrollment. As this care planning process may result in unanticipated changes to a beneficiary's existing care, such changes could impact a beneficiary's experience and understanding of the plan in a way that may influence their decision around whether to remain enrolled. Aligning the period of the SEP with requirements around the care planning process would ensure that a beneficiary has all the information they need to make an educated decision about whether to remain in the plan to which they have been assigned.

- To further promote integrated care and alignment with the Medicaid Managed Care Rule, we also urge CMS to permit members enrolled in integrated products to disenroll from the integrated product either for any of the "for cause" disenrollment reasons set forth at 42 CFR § 438.56(d)(2) or for any reason permitted pursuant to the state Medicaid agency's managed care contract for Medicaid coverage through the integrated product. As a specific example, in Massachusetts, as a condition of participation in our Senior Care Options program (SCO, a FIDE SNP), a dual eligible beneficiary seeking to enroll in one of the SCO plans must simultaneously enroll in the plan's affiliated Medicaid managed care organization (MCO) and its Medicare D-SNP. Among other things, the Medicaid Managed Care Rule describes a change to the enrollee's residential, institutional, or employment supports provider as a result of the provider's change from in-network to out-of-network as a "for cause" disenrollment reason from a Medicaid MCO. These providers and services may be covered through the State's contract with the Medicaid MCO part of the FIDE SNP, but if a beneficiary had this reason to disenroll from the plan's Medicaid coverage, he or she would also need to be allowed to disenroll from the plan's Medicare D-SNP coverage. CMS's SEP rule should consider both the Medicare and Medicaid enrollment impacts as part of the exceptions processes.

- Additionally, we note the preamble states that beneficiaries who have been enrolled in a plan by CMS or a state would be allowed a separate, additional use of the SEP. We request that CMS confirm that this means that states may make passive enrollment decisions where otherwise permitted, such as in MMPs, regardless of whether an individual has exhausted his or her SEP options for the year.

- Finally, we appreciate CMS's proposal to apply SEPs to Medicare Part D plans, which will include MA-PDs, D-SNPs, and MMPs. We also encourage CMS to apply the SEPs to Medicare Advantage plans without Part D coverage and to Original Medicare as well. We are concerned that exempting these products (where they don't include Part D coverage) for dual eligible individuals could create unintended confusion for beneficiaries about when they have the option to change their Medicare Part A and Part B benefits during the year.

Massachusetts also supports CMS' efforts to enact additional limitations on the ability of beneficiaries who are identified as at-risk or potentially-at-risk of opioid misuse to change Part D plans frequently (while still permitting a SEP for these groups pursuant to a change in their Medicaid or LIS status and/or assignment to a plan by CMS or a State). Massachusetts is committed to curbing opioid addiction and believes this would support our efforts. To further assist in these efforts to curb opioid misuse, Massachusetts requests that CMS share data about any at-risk or potentially-at-risk dual eligible members in Part D plans who are subject to these SEP limitations to target Medicaid wrap services, including supplemental behavioral health and substance use treatment services.

As CMS moves to finalize these new SEP policies, we encourage CMS to offer increased resources to State Health Insurance Assistance Programs (SHIPs) to provide targeted outreach to the dual eligible and LIS populations who will be impacted by these changes. CMS should also provide concurrent outreach and education to providers and pharmacies about these changes, including mental health and substance use providers, as well as community based organizations (such as recovery learning communities), as these changes have a specific impact on beneficiaries with substance use disorders.

These efforts will help ensure that beneficiaries most likely to be impacted by these changes, and their providers, are made aware well in advance of implementation.

Further, since these new SEPs will mean that dual eligible beneficiaries will be more limited in their ability to change plans once enrolled, we strongly encourage CMS and the Administration for Community Living (ACL) to provide continued funding for state Ombudsman programs that serve dual eligible populations enrolled in Demonstration products, and to allow states to use this funding to serve dual eligible beneficiaries enrolled in any integrated care product, including, e.g. FIDE SNPs. Ombudsman programs play a crucial role in ensuring beneficiaries understand their rights and have access to the care and services they need.

Limited Authorization of seamless conversion (default enrollment) from Medicaid plans into D-SNPs

Massachusetts supports the proposed availability of default enrollment for newly dual eligible beneficiaries becoming Medicare eligible from a Medicaid managed care plan into an integrated D-SNP offered by the same carrier. However, we request and recommend the following changes and clarifications to the proposed rule:

- CMS should clarify that eligible Medicaid coverage as described in 42 CFR § 422.66(c)(2)(i)(A) may be provided through any Medicaid managed care entity subject to regulation under 42 CFR part 438, including Medicaid contracted managed care organizations (MCOs), prepaid inpatient health Plans (PIHPs), prepaid ambulatory health Plans (PAHPs), and primary care case management (PCCM) entities. Furthermore, as states experiment with developing new delivery systems such as accountable care organizations (ACOs), the rule should be flexible enough to accommodate these innovative approaches. For example, over the past two years, MassHealth has been working to restructure its care delivery structure to promote new, integrated care models for Medicaid-only beneficiaries that include ACOs. Medicaid beneficiaries who are enrolled in these new types of state innovated models should also be eligible for default enrollment into an integrated Medicare D-SNP operated by or affiliated with the same parent company. Additionally, CMS should consider coordinating with the state to allow for alignment when assigning beneficiaries to a Medicare ACO.

- CMS should clarify in 42 CFR § 422.66(c)(2)(i) that the default enrollment process may be used both for individuals entitled to medical assistance under a State plan under Title XIX, and for individuals eligible for medical assistance under a waiver.

- We appreciate CMS's recognition of the state's role in approving default enrollment processes as a condition of CMS approval, as described in 42 CFR § 422.66(c)(2)(i)(B). States may also need to take a more active role in managing ongoing default enrollment processes when the state contracts for Medicaid services through the D-SNP (such as for FIDE SNPs). It will be important for states to retain authority to make adjustments to default enrollment volume in concert with the D-SNPs, and for states to have transparent access to data about the enrollments real-time.

- Under the proposed rule, CMS has proposed narrowing its prior practice by permitting seamless enrollment into an MA plan of newly-Medicare eligible individuals only if, among other things, they are currently enrolled in a Medicaid managed care plan. Massachusetts suggests that, for individuals gaining dual eligibility, CMS should permit default enrollment into a D-SNP or FIDE SNP product when, at the time of conversion, they are enrolled in a Medicaid product or a commercial product offered by the same parent organization as the D-SNP or FIDE SNP product, and the other proposed conditions for default enrollment set forth at 42 CFR § 422.66(c)(2)(i)(B)-(E) are met. Newly dual eligible beneficiaries who may have previously been enrolled in commercial products could greatly benefit from the continuity of care advantages afforded by default enrollment into integrated products offered by the same parent entities.

- We further respectfully request that CMS additionally expand opportunities for states to use the default enrollment process, or broader passive enrollment processes such as are available to states operating MMPs, to enroll any dual eligible beneficiary – whether currently a dual eligible beneficiary or an individual who has become a dual eligible beneficiary by virtue of gaining eligibility for Medicaid, Medicare, or both – into an integrated D-SNP or FIDE SNP product. Massachusetts strongly believes in the value integrated care can bring to beneficiaries, and believes that states should have more tools to encourage beneficiary participation in these models.

To maximize these default enrollment opportunities for all beneficiaries, Massachusetts strongly recommends that CMS make this default enrollment an option available for both the aged population and younger, disabled beneficiaries. We share CMS's concern that limiting default enrollment to aged populations could result in disparate treatment among newly eligible individuals based on their reason for obtaining Medicare entitlement.

To ensure successful implementation of default enrollment options, it is critical that States be allowed to serve as equal partners with CMS in determining which plans may participate and under what circumstances, particularly for states such as Massachusetts, who have capitated financial arrangements with MMP and FIDE SNP carriers that have been selected via full and fair procurements to provide integrated Medicaid services to dual eligible beneficiaries.

Limited Expansion of Passive Enrollment Authority

Massachusetts supports the proposal to expand the existing authority of CMS to allow passive enrollment of members from one D-SNP into another D-SNP when it determines "that the passive enrollment will promote integrated care and continuity of care for a full-benefit dual eligible beneficiary," (e.g., disruptions due to state re-procurement of Medicaid managed care contracts, or non-renewal of D-SNP contracts). At a minimum, Massachusetts urges CMS to similarly allow passive enrollment from MMPs into D-SNP products under similar circumstances, but as with default enrollment, Massachusetts strongly urges CMS to go further in supporting state efforts to promote enrollment in integrated care products.

In particular, Massachusetts supports broader state authority to increase enrollment of dual eligible beneficiaries in fully integrated systems of care, including passive enrollment for existing dual eligible

and new dual eligible beneficiaries (regardless of whether the beneficiary gained Medicaid- or Medicare-eligibility first) into integrated D-SNPs without a triggering event (such as change in eligibility by virtue of age or disability or to prevent disruption post-re-procurement or non-renewal of D-SNP plans), including beneficiaries in FFS and stand-alone Part D plans. Currently, Massachusetts has authority to passively enroll dual eligible beneficiaries ages 21 through 64 into our MMPs through a Financial Alignment Initiative (FAI) demonstration. Encouraged by the high-quality scores from the first few years for all of its MMPs, Massachusetts is seeking authority to passively enroll dual-eligible beneficiaries into our FIDE-SNP (SCO) program, for members age 65 and over.

As with default enrollment and the integrated enrollment process used for MMPs, it is critical that States be allowed to serve as equal partners with CMS in determining plan participation, volume, and overall process for passive enrollment. This will be particularly important for states such as Massachusetts, who have capitated financial arrangements with the both MMP and FIDE SNP carriers.

While we agree with several of the criteria CMS proposes for a plan to be able to accept passive enrollments, Massachusetts is concerned that limiting passive enrollment to plans with substantially similar provider and facility networks as described at 42 CFR § 422.50(g)(2)(ii) may unnecessarily narrow the scope of permissible passive enrollments in circumstances in which, for example, an individual beneficiary's primary and/or behavioral health or LTSS providers may be part of both plans, even though the overall provider and facility networks may differ. This is particularly true for individuals who are not residing in a facility. It is also unclear how network similarity would be measured, and by which agency, and what the standard for substantially similar networks would be. Particularly with the introduction of ACOs in many states, many providers have consolidated their network affiliations. As an example, Massachusetts required primary care providers in its contracted Medicaid ACOs to exclusively contract with that ACO, and not with other Medicaid MCOs or MassHealth's Primary Care Clinician plan. We believe that the presence of one or more of an individual's current providers may be an appropriate consideration in individual assignments when available, but we also believe that transparent beneficiary noticing requirements, the option for a beneficiary to decline the enrollment (opt-out), and initial continuity of care protections for prior provider relationships are more appropriate requirements that advance the goal of sustaining enrollment in integrated care products, while respecting individual beneficiary decisions and preferences.

Similar to the passive enrollment process for MMPs, Massachusetts requests that states retain flexibility to work collectively with CMS to determine when passive enrollment may be appropriate. For example, regarding quality standards, MA star ratings do not capture performance of the services covered under Medicaid, and Massachusetts would like flexibility to take into account patient experience and care components of the stars methodology (CAHPS and HOS), as well as other potential factors affecting plan capacity to ensure access to care for individuals passively enrolled, including, for instance, assessment completion rates and overall contract performance. In certain circumstances, plans may meet a particular set of minimum quality standards, but the state and CMS may decide that other factors should preclude a plan from being assigned passive enrollees.

In addition, in this limited context of transitioning beneficiaries between plans through passive enrollment, we agree overall that as prudent payers we need to be conscious of the cost-

effectiveness of plans. However, the proposed flexibility needs to be considered in the specific context of plan bidding practices and other factors specific to the program market. Massachusetts would recommend that cost-effectiveness be one of several factors considered by the State and CMS as part of the approval process for a passive enrollment, rather than a stand-alone requirement. If CMS retains the cost effectiveness test, we suggest that CMS and the State have discretion to collaboratively determine cost effectiveness across the combined Medicare and Medicaid programs, and to take into account potential year-to-year variations in plan Medicare bidding strategies, including bidding relative to the benchmark, supplemental benefits, as well as Medicaid rate structure and variation.

Massachusetts has also been working to better align administrative requirements, including beneficiary noticing, across its MMP and FIDE-SNP products. We support CMS's proposal that D-SNPs must provide at least one notice to beneficiaries, as that aligns with the noticing requirements in the Medicaid Managed Care Rule.

Massachusetts also urges CMS to provide states with opportunities to more fully integrate Medicaid and Medicare noticing within integrated products, including D-SNPs, similar to MMPs, outside of the passive enrollment processes.

Provisions Impacting the Programs of All-Inclusive Care for the Elderly (PACE)

Massachusetts welcomes the proposed changes to the PACE provider conditions of payment and the use of a "preclusion list" that would prohibit PACE organizations from paying for items or services by an individual or entity that is either excluded by OIG or included on the preclusion list.

Other Comments

The Medical Loss Ratio (MLR) reporting requirements provide important data that supports the federal government and states to be effective and efficient purchasers. Massachusetts does not object to the federal reduction in data details to support MLR submissions by Medicare Advantage plans to CMS; however, it will be critically important for states to maintain their ability to specify and require detailed reporting of financial and MLR data through MIPAA contracting authority, Financial Alignment Initiatives, and other coordinated and integrated mechanisms. States need visibility into the financial performance of their vendors, particularly for products that include both Medicare and Medicaid funding and services.

In addition to the proposed changes to Meaningful Differences in Medicare Advantage Bid Submissions and Bid Review (42 CFR §§ 422.254 and 422.256), Massachusetts suggests that CMS considering requiring bids for highly coordinated D-SNP plans and FIDE-SNP plans be submitted under a separate contract number. This would improve transparency for beneficiaries and for states into the cost and quality of integrated Medicare and Medicaid plan offerings.

Massachusetts' FIDE and MMP plans are subject to both state and federal measures of the quality of the entire set of Medicare and Medicaid covered services. As a Commonwealth we are seeking to align those measure sets across our delivery platforms (FIDE, MMP, Medicaid health plan, and Medicaid fee for service) to assure that consumers can make apples to apples comparisons of the plans and programs available to them. We support the removal of the QIP requirement and believe

that it will allow plans to reallocate limited resources to these crosscutting measures of quality including overall consumer experience of care.

Finally, Massachusetts requests that CMS consider publishing or otherwise making available to states star rating data that can be filtered or otherwise compared between plans by population type and age (i.e. for dual eligible individuals vs. Medicare-only beneficiaries; and by beneficiaries under age 65 vs. age 65 and over).

We thank you for consideration of our comments and look forward to continuing to work with our federal partners.

Sincerely,

Marylou Sudders

Secretary, Executive Office of Health and Human Services

cc: Daniel Tsai, Assistant Secretary for MassHealth