



## Medicare Advantage Plans

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Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4182-P  
P.O. Box 8010  
Baltimore, Maryland 21244-8010

**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 (82 *Federal Register* 56336 (Nov. 28, 2017) and 82 *Federal Register* 61519 (Dec. 28, 2017))**

Dear Centers for Medicare and Medicaid Services:

Blue Cross of Idaho Health Service, Inc. and Blue Cross of Idaho Care Plus, Inc. (collectively, "Blue Cross of Idaho") appreciate the opportunity to comment on 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," published at 82 *Federal Register* 56336 on November 28, 2017 and corrected at 82 *Federal Register* 61519 on December 28, 2017 ("CY2019 Medicare Program NPRM").

### **Interest of Blue Cross of Idaho**

Blue Cross of Idaho Health Service, Inc. ("BCI") is the parent organization of Blue Cross of Idaho Care Plus, Inc. ("ICP"). Each is a not-for-profit mutual insurance corporation; BCI is licensed as a health insurance issuer and ICP is licensed as a managed care organization by the State of Idaho Department of Insurance. Collectively, they offer commercial, Marketplace, Medicare Advantage, Medicare-Medicaid dual eligible, and ancillary lines of business throughout the State of Idaho. They are independent licensees of the Blue Cross Blue Shield Association.

ICP contracts with the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage ("MA") plans to Medicare beneficiaries residing in various counties in the State of

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Idaho. ICP and/or BCI has participated in the MA program and its predecessor, the Medicare+Choice program, since the late 1990s. Over the years, ICP and BCI have offered a variety of MA coordinated care plans, including dual-eligible special needs plans (“D-SNPs”).

ICP, together with BCI, also contracts with the Idaho Department of Health and Welfare (“IDHW”), the State Medicaid agency, to offer the Medicare-Medicaid Coordinated Plan (“MMCP”). The MMCP is targeted to Idaho’s more than 26,000 Medicaid participants who are also eligible for Medicare (“dual eligibles”). The current iteration of the MMCP, which has been operational since 2014, coordinates and integrates Medicare Parts A, B and D benefits, most Medicaid benefits (including long-term services and supports), and some supplemental benefits for full-benefit dual eligibles over age 21.

The MMCP has been approved by CMS as a fully-integrated dual eligible special needs plan (“FIDE SNP”). As such, the MMCP is administered by ICP in several Idaho counties pursuant to one of the MA contracts between ICP and CMS and pursuant to a managed care organization risk-based contract among ICP, BCI and IDHW. ICP has administered the current iteration of the MMCP since 2014. ICP is joined by a second MMCP administrator for 2018—Molina Healthcare of Idaho.

### **Focus and Objectives of Blue Cross of Idaho’s Comments**

CMS explains in the CY2019 Medicare Program NPRM preamble that CMS seeks to make changes and enhancements to the MA and Part D program regulations that “support innovative approaches to improving quality, accessibility, and affordability.” 82 *Fed. Reg.* at 56339. CMS states that the changes and enhancements it seeks to make are informed by its “continued experience in the administration of the [MA] and Part D programs.” *Id.* Accordingly, the CY2019 Medicare Program NPRM aims to “reduce burden and provide the regulatory framework to develop MA and Part D products that better meet the individual beneficiary’s healthcare needs.” *Id.*

Blue Cross of Idaho compliments CMS on its experience-driven, improvement-oriented approach to proposing modifications to the MA and Part D program regulations for CY2019. For this letter, Blue Cross of Idaho focuses its comments on CMS’s proposals addressing mechanisms to facilitate enrollment of individuals eligible for both Medicare and Medicaid into D-SNPs and, particularly, FIDE SNPs. Blue Cross of Idaho’s comments are, therefore, limited to Section II.A.7 (*Coordination of Enrollment and Disenrollment and Effective Dates of Coverage and Changes of Coverage*) and Section II.A.8 (*Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dually Eligible Beneficiaries*) of the CY2019 Medicare Program NPRM.

Blue Cross of Idaho is persuaded, both by its own experience and by third party assessment, that dually eligible individuals are best served when coverage of their Medicare and Medicaid

benefits is coordinated and integrated through a single entity or a single corporate family via a D-SNP (and especially via a highly integrated D-SNP, such as a FIDE SNP). The objectives of Blue Cross of Idaho's comments, accordingly, are to explain:

- (a) Why, under policy and law, CMS should clarify proposed 42 C.F.R. § 422.66(c)(2) to permit MA organizations satisfying that section's conditions to "default enroll" newly Medicare-eligible Medicaid participants into D-SNPs, including FIDE SNPs like the MMCP that fully integrate Medicare and Medicaid benefits in a single plan offered by a single entity; and
- (b) Why, under policy and law, CMS should extend proposed 42 C.F.R. § 422.60(g) to permit CMS to "passively enroll" full-benefit dual eligibles into highly integrated D-SNPs (including FIDE SNPs), not only when the full-benefit dual eligible's existing coverage under a highly integrated D-SNP is involuntarily disrupted, *but* when a State Medicaid agency elects to exercise its federal regulatory permission to undertake "passive enrollment" of full-benefit dual eligibles into a voluntary Medicaid managed care option underlying highly integrated D-SNPs in the State, subject in both cases to the receiving MA organization satisfying specified conditions for receiving those "passive enrollments."

Blue Cross of Idaho's comments include recommended revisions to the proposed regulatory text to clarify that these objectives are enabled by the regulatory text CMS adopts pursuant to the CY2019 Medicare Program NPRM.

### COMMENTS

**1. CY2019 Medicare Program NPRM Section II.A.7 (Coordination of Enrollment and Disenrollment and Effective Dates of Coverage and Changes of Coverage, 42 C.F.R. § 422.66(c))**

**a. Comments on CY2019 Medicare Program NPRM Section II.A.7 Specific to 42 C.F.R. § 422.66(c)(2)**

- i. CMS should finalize its proposal to codify qualifying MA organizations' use of "default enrollment" of newly Medicare-eligible Medicaid participants into D-SNPs.

Blue Cross of Idaho supports CMS's proposal in Section II.A.7 of the CY2019 Medicare Program NPRM to reinstate the opportunity for qualifying MA organizations to deploy "default enrollment" of certain individuals newly eligible for Medicare into MA plans that are D-SNPs. That will codify permission for a MA organization to "default enroll" newly Medicare-eligible Medicaid participants into a D-SNP offered by the MA

organization (or by a MA organization with the same parent), provided the MA organization satisfies conditions specified in 42 C.F.R. § 422.66(c)(2).

The conditions that CMS specifies for a MA organization's use of "default enrollment" ensure appropriate beneficiary protection. The reason is those conditions will require, among other protections:

- 1) Approval of both the State Medicaid agency and CMS of a MA organization's use of "default enrollment" for a particular D-SNP; and
- 2) Notice 60-days in advance by the MA organization to each newly Medicare-eligible Medicaid participant of "default enrollment" into the MA organization's D-SNP, with the right to opt out and elect enrollment into Original Medicare or another MA plan.

CMS observes in the CY2019 Medicare Program NPRM preamble that such "default enrollment" is "in line with CMS' support of state efforts to increase enrollment of dually eligible individuals in fully integrated systems of care and the evidence that such systems improve health outcomes." 82 *Fed. Reg.* at 56366-67. By finalizing its "default enrollment" proposal, CMS would give both State Medicaid agencies and MA organizations offering D-SNPs assurance of the availability and predictability of "default enrollment"; that assurance and predictability better positions MA organizations with D-SNPs to coordinate enrollment strategies with their States' Medicaid agencies for the benefit of the dual eligible population that those State Medicaid agencies serve and those MA organizations seek to serve.

- ii. CMS should clarify that the definition of "affiliated Medicaid managed care plan," included in its "default enrollment" proposal, applies to FIDE SNPs that fully integrate Medicare and Medicaid benefits in a single plan offered by a single entity.

Another of the conditions CMS specifies for a MA organization's use of "default enrollment" requires that, "[a]t the time of the deemed election, the individual remains enrolled in an affiliated Medicaid managed care plan." 82 *Fed. Reg.* at 56494 (proposing to codify 42 C.F.R. § 422.66(c)(2)(i)(A)). The CY2019 Medicare Program NPRM proposes to define "affiliated Medicaid managed care plan" as "one that is offered by the MA organization that offers the MA special needs plan for individuals entitled to medical assistance under Title XIX or is offered by an entity that shares a parent organization with such MA organization." 82 *Fed. Reg.* at 56494 (proposing to codify 42 C.F.R. § 422.66(c)(2)(i)(A)).

CMS should clarify that definition's application so that it does not foreclose the availability of "default enrollment" by a MA organization offering one plan through a single entity comprising both the MA D-SNP and the "affiliated Medicaid managed care plan." In other words, a single plan from a single entity, such as a FIDE SNP like the MMCP, could fulfill the role of both the enrolling MA D-SNP and the remaining "affiliated Medicaid managed care plan" for purposes of qualifying a MA organization for use of "default enrollment." This CMS clarification would ensure that a MA organization offering such FIDE SNP will have an "affiliated Medicaid managed care plan" in which the newly Medicare-eligible Medicaid participant "remains enrolled" when the individual is "default enrolled" into the MA organization's FIDE SNP.

- iii. CMS has authority under the Social Security Act to clarify the "affiliated Medicaid managed care plan" definition to enable "default enrollment" of newly Medicare-eligible Medicaid participants into FIDE SNPs fully integrating Medicare and Medicaid benefits in a single plan offered by a single entity.

No law disqualifies a MA organization offering a FIDE SNP—which fully integrates Medicare and Medicaid benefits in a single plan through a single entity—from being approved by both the State Medicaid agency and CMS to "default enroll" newly Medicare-eligible Medicaid participants into the FIDE SNP. To the contrary the Social Security Act empowers CMS to permit such "default enrollment."

In the CY2019 Medicare Program NPRM, CMS points to Section 1851(c)(3)(A)(ii) of the Social Security Act as legal authority for "default enrollment" of newly Medicare-eligible Medicaid participants into D-SNPs per proposed 42 C.F.R. § 422.66(c)(2). That Social Security Act section permits CMS to "establish procedures under which an individual who is enrolled in a health plan (other than [a] Medicare[ Advantage] plan) offered by a Medicare[ Advantage] organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare[ Advantage] plan offered by the organization." Social Security Act § 1851(c)(3)(A)(ii).

Section 1851(c) of the Social Security Act also provides legal authority for "default enrollment" of newly Medicare-eligible Medicaid participants into D-SNPs and, especially, FIDE SNPs like the MMCP. Social Security Act § 1851(c)(1) mandates that CMS "establish a process through which elections [of Original Medicare or Medicare Advantage] are made and changed, including the form and manner in which such elections are made and changed." Social Security Act § 1851(c)(2)(A) further provides that "such process shall permit an individual who wishes to elect a Medicare[ Advantage] plan offered by a Medicare[ Advantage] organization to make such election

through the filing of an appropriate election form with the organization.” Social Security Act § 1851(c)(2)(a).

Existing paragraph “(a)” of 42 C.F.R. § 422.66 reflects CMS’s fulfillment of the Social Security Act mandate to establish election processes with its reference, not only to “filing of the appropriate election form” with a MA organization as one means to elect a MA plan, but also “through other mechanisms as determined by CMS.” 42 C.F.R. § 422.66(a). Those “other mechanisms” include “default enrollment” as described in proposed 42 C.F.R. § 422.66(c)(2) under the broad caption “*Election by default: Initial coverage election period.*” 82 *Fed. Reg.* at 56494 (proposing to codify the caption for 42 C.F.R. § 422.66(c)). Put differently, “default enrollment” is an election process for a MA plan specific to the initial coverage election period that CMS has the statutory authority to establish with respect to both its form and manner. *See* 70 *Fed. Reg.* 4588, 4606 (Jan. 28, 2005) (“[w]e believe that we can achieve the same flexibility provided with respect to default enrollment that exists at § 422.60[(c)], which allows for elections using alternative mechanisms”).

There is no statutory limitation on CMS’s fulfillment of the mandate of Social Security Act § 1851(c)(1) to establish election processes, as contemplated by CMS’s “default enrollment” proposal. The only limitation implicit in Social Security Act § 1851 is that the election processes CMS establishes must not vitiate an individual’s right to choose between Original Medicare or Medicare Advantage at the time of the individual’s initial election period. CMS’s “default enrollment” proposal and Blue Cross of Idaho’s recommended clarification of that proposal—particularly in the context of highly integrated D-SNPs, such as FIDE SNPs—does not undermine individual Medicare beneficiary choice.

Rather, what they do is enable MA organizations, with State Medicaid agency and CMS approval, to “nudge” through “default enrollment” newly Medicare-eligible Medicaid participants into D-SNPs, which CMS, many State Medicaid agencies, and other interested stakeholders (including Blue Cross of Idaho) have determined serve the best interest of newly Medicare-eligible Medicaid participants. Yet, because individuals must be informed by MA organizations of their “default enrollment” and their right to choose their Medicare coverage under proposed 42 C.F.R. § 422.66(c)(2)(iv), they always retain the right to opt out and elect Original Medicare or another MA plan.

- iv. CMS’s approval of a MA organization’s use of “default enrollment” should not be time-limited.

Blue Cross of Idaho agrees with CMS that approval of a MA organization’s use of “default enrollment” should not be time-limited. To impose a time limit, such as 5 years,

would impose unnecessary burden on a MA organization approved to use “default enrollment.” The reason is the MA organization would have to re-demonstrate its qualification under the MA program regulations to receive “default enrollments” in a D-SNP prior to or at expiration of its current approval, even if no basis existed for believing the MA organization does not continue to so qualify.

CMS is adequately protected against MA organization abuse of the “default enrollment” mechanism by its reservation of the right to “suspend or rescind approval when CMS determines the MA organization is not in compliance with the requirements” for “default enrollments.” 82 *Fed. Reg.* at 56494 (proposing to codify 42 C.F.R. § 422.66(c)(2)(ii)). CMS has the opportunity to learn of such non-compliance through its ongoing monitoring and oversight of MA organizations, receipt of dual eligible or other stakeholder complaints, and ongoing consultation with the State Medicaid agencies that have granted approval of a MA organization’s use of “default enrollment.”

- v. CMS’s ongoing and timely furnishing of data to State Medicaid agencies that enable identification of newly Medicare-eligible Medicaid participants is essential for State Medicaid agencies to support MA organizations’ compliant “default enrollment” of those Medicaid participants into D-SNPs.

Another condition CMS specifies in proposed 42 C.F.R. § 422.66(c)(2) for a MA organization’s use of “default enrollment” is that the State Medicaid agency furnishing its approval of the MA organization’s use of “default enrollment” will “provide[] the information that is necessary for the MA organization to identify individuals who are in their initial coverage election period” for Medicare. 82 *Fed. Reg.* at 56494 (proposing to codify 42 C.F.R. § 422.66(c)(2)(i)(B)). Blue Cross of Idaho supports that condition, but emphasizes the reliance the State Medicaid agencies must place on CMS to be able to fulfill that condition.

CMS states in the CY2019 Medicare Program NPRM that, “[a]s part of the coordination between the Medicare and Medicaid programs, CMS shares with states, via the State MMA file, data of individuals with Medicaid who are newly becoming entitled to Medicare; such data includes the Medicare number of newly eligible Medicare beneficiaries.” 82 *Fed. Reg.* at 56366. It is receipt of these data upon which State Medicaid agencies must depend to be able to provide MA organizations with the information needed to identify Medicaid participants who are newly eligible for Medicare because of age or disability and satisfy their “default enrollment” notice obligation to those Medicaid participants. Accordingly, CMS must ensure State Medicaid agencies’ ongoing and timely receipt of these data essential to compliant “default enrollment” by those MA organizations approved by CMS and State Medicaid agencies to use “default enrollment.” That will enable those MA organizations to give the

required “default enrollment” notice to newly Medicare-eligible Medicaid participants and preserve their opt out right to choose Original Medicare or another MA plan.

*b. Recommended Revisions to Proposed 42 C.F.R. § 422.66(c)(2)*

Blue Cross of Idaho recommends the following revisions to clarify that the text of proposed 42 C.F.R. § 422.66(c)(2) permits MA organizations satisfying that section’s conditions to “default enroll” newly Medicare-eligible Medicaid participants into D-SNPs, including FIDE SNPs that fully integrate Medicare and Medicaid benefits in a single plan offered by a single entity. The double-underlined text reflects proposed additions, and the double-strikethrough text reflects proposed deletions.

*“(c) Election by default: Initial coverage election period— \* \* \**

*“(2) Default enrollment into MA special needs plan—(i) Conditions for default enrollment. During an individual’s initial coverage election period, an individual may be deemed to have elected a MA special needs plan for individuals entitled to medical assistance under a State plan under Title XIX offered by ~~the~~ a MA organization, including a fully integrated dual eligible special needs plan, provided all the following conditions are met:*

*“(A) At the time of the deemed election, the individual remains enrolled in an affiliated Medicaid managed care plan. For purposes of this section, an affiliated Medicaid managed care plan is one that is independent of or integrated with the MA special needs plan for individuals entitled to medical assistance under Title XIX that is offered by the MA organization that offers ~~the such MA special needs plan for individuals entitled to medical assistance under Title XIX~~ or is offered by an entity that shares a parent organization with such MA organization;*

*“(B) The state has approved the use of the default enrollment process in the contract described in § 422.107 and provides the information that is necessary for the MA organization to identify individuals who are in their initial coverage election period;*

*“(C) The MA organization offering the MA special needs plan has issued the notice described in paragraph (c)(2)(iv) of this section to the individual;*

*“(D) Prior to the effective date described in paragraph (c)(2)(iii) of this section, the individual does not decline the default*



enrollment and does not elect to receive coverage other than through the MA organization; and

“(E) CMS has approved the MA organization to use default enrollment under paragraph (c)(2)(ii) of this section.

“(ii) *CMS approval of default enrollment.* A MA organization must obtain approval from CMS before implementing any default enrollment as described in paragraph (c)(2) of this section. CMS may suspend or rescind approval when CMS determines the MA organization is not in compliance with the requirements of paragraph (c)(2) of this section.

“(iii) *Effective date of default enrollment.* Default enrollment in the MA special needs plan for individuals entitled to medical assistance under a State plan under Title XIX, including a fully integrated dual eligible special needs plan, is effective the month in which the individual is first entitled to both Part A and Part B.

“(iv) *Notice requirement for default enrollments.* The MA organization must provide notification that describes the costs and benefits of ~~the MA plan~~ and the process for accessing care under the MA special needs plan and clearly explains the individual’s ability to decline the enrollment, up to and including the day prior to the enrollment effective date, and either enroll in Original Medicare or choose another MA plan. Such notification must be provided to all individuals who qualify for default enrollment under paragraph (c)(2) of this section no fewer than 60 calendar days prior to the enrollment effective date described in paragraph (c)(2)(iii) of this section.”

*Compare 82 Fed. Reg. at 56494 (proposing to codify 42 C.F.R. § 422.66(c)(2)).*

**2. CY2019 Medicare Program NPRM Section II.A.8 (Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dually Eligible Beneficiaries, 42 C.F.R. § 422.60(g))**

**a. Comments on CY2019 Medicare Program NPRM Section II.A.8 Specific to 42 C.F.R. § 422.60(g)**

- i. CMS should finalize its proposal to permit itself to undertake “passive enrollment” of full-benefit dual eligibles facing involuntary disruption of their coverage under one highly integrated D-SNP into another qualifying MA organization’s highly integrated D-SNP.

Blue Cross of Idaho supports CMS’s proposal in Section II.A.8 of the CY2019 Medicare Program NPRM to permit CMS to “passively enroll” full-benefit dual eligibles facing involuntary disruption of their existing coverage under a highly integrated D-SNP into another highly integrated D-SNP offered by a MA organization that satisfies the conditions of proposed 42 C.F.R. § 422.60(g)(2). As CMS observes in the CY2019 Medicare Program NPRM, this proposed extension of “passive enrollment” “promote[s] continued enrollment of [full-benefit] dually eligible beneficiaries in integrated care plans to preserve and promote care integration.” 82 *Fed. Reg.* at 56369.

- ii. CMS should also permit itself to “passively enroll” full-benefit dual eligibles residing in States where the State Medicaid agency elects to undertake “passive enrollment,” as permitted under applicable Medicaid law, with respect to the voluntary Medicaid managed care option underlying the State’s highly integrated D-SNPs.

CMS should also give itself regulatory permission to “passively enroll” full-benefit dual eligibles into highly integrated D-SNPs offered by MA organizations that satisfy the conditions of proposed 42 C.F.R. § 422.60(g)(2) in one other circumstance. That circumstance is when the Medicaid agency in the State where the full-benefit dual eligibles reside elects to undertake “passive enrollment” of Medicaid participants (including or limited to full-benefit dual eligibles) into the voluntary Medicaid managed care option underlying the State’s highly integrated D-SNPs, as permitted under the voluntary Medicaid managed care program regulations at 42 C.F.R. § 438.54(c).

This extension of CMS’s permission to undertake “passive enrollment” for the MA program is supported by the compelling case that CMS itself makes for the positive effects of full-benefit dual eligibles’ enrollment in highly integrated D-SNPs. The opening paragraph of the CY2019 Medicare Program NPRM preamble discussing CMS’s “passive enrollment” proposal stresses:

“Beneficiaries who are dually eligible for both Medicare and Medicaid typically face significant challenges in navigating the two programs . . . . Fragmentation between the two programs can result in a lack of coordination for care delivery . . . . One method for overcoming this challenge is through integrated care, which provides dually eligible beneficiaries with the full array of Medicaid and Medicare benefits for which they are eligible through a single delivery system, thereby *improving quality of care, beneficiary satisfaction, care coordination, and reducing administrative burden.*” 82 Fed. Reg. at 56369 (emphasis added).

CMS goes on to explain that access to such “integrated care” can be obtained by full-benefit dual eligibles by their enrollment in a “variety of integrated D-SNPs”—including FIDE SNPs and other D-SNPs that CMS recognizes as highly integrated—offered by MA organizations. *Id.* Given that integrated D-SNPs improve care quality, beneficiary satisfaction and care coordination and reduce administrative burden of full-benefit dual eligibles, CMS should seek to increase enrollment of full-benefit dual eligibles in that MA plan option.

CMS should, accordingly, establish the regulatory process for CMS to undertake “passive enrollment” of full-benefit dual eligibles into highly integrated D-SNPs when a State Medicaid agency elects to exercise its federal regulatory permission to undertake “passive enrollment” of Medicaid participants (including or limited to full-benefit dual eligibles) into a voluntary Medicaid managed care option underlying highly integrated D-SNPs in the State. By establishing this regulatory process, CMS will be able to partner with State Medicaid agencies in effecting the “passive enrollment” of full-benefit dual eligibles into highly integrated D-SNPs to optimize the positive effects for those dual eligibles of enrollment in an “integrated care” option.

- iii. CMS has the statutory authority to extend itself regulatory permission to undertake “passive enrollment,” not only as CMS proposes in the CY2019 Medicare Program NPRM, but as Blue Cross of Idaho recommends in this letter.

CMS has statutory authority to establish the regulatory process to undertake “passive enrollment” of full-benefit dual eligibles into highly integrated D-SNPs when a State Medicaid agency elects to exercise its federal regulatory permission to undertake “passive enrollment” of Medicaid participants who are full-benefit dual eligibles into a voluntary Medicaid managed care option underlying highly integrated D-SNPs in the State. That authority rests in the mandate of Social Security Act § 1851(c)(1) that CMS “establish a process through which elections [of Original Medicare or Medicare

Advantage] are made and changed, including the form and manner in which such elections are made and changed.” Social Security Act § 1851(c)(1).

CMS’s fulfillment of that statutory mandate must honor the beneficiary’s right to choose that animates Section 1851 of the Social Security Act. But honoring beneficiary choice does *not* preclude the “nudge” of “passive enrollment” into a highly integrated D-SNP that is generally the beneficiary’s best choice. Indeed, the Social Security Act does not impose constraints on how CMS carries out the mandate, except to require that the process “permit an individual who wishes to elect a Medicare[ Advantage] plan offered by a Medicare[ Advantage] organization to make such election through the filing of an appropriate election form with the organization.” Social Security Act § 1851(c)(2)(a).

The extensions of “passive enrollment” that CMS proposes in the CY2019 Medicare Program NPRM and Blue Cross of Idaho recommends in this letter are consistent with the statutory directive that CMS establish the form and manner in which Medicare coverage elections are made. The “passive enrollment” permission set forth in proposed 42 C.F.R. § 422.60(g) requires that the MA organization receiving “passive enrollment” notify the full-benefit dual eligibles being “passively enrolled” under proposed 42 C.F.R. § 422.60(g)(1)(iii) of their “passive enrollment” and of their right to decline the “passive enrollment” or elect enrollment in another MA plan with the filing of an appropriate election form. That notice obligation (especially when paired with the separately required special enrollment period for “passively enrolled” full-benefit dual eligibles) ensures that a full-benefit dual eligible’s right to choose is preserved.

- iv. The conditions that a MA organization’s highly integrated D-SNP must satisfy to receive “passive enrollment” protect the rights and interests of full-benefit dual eligibles.

Blue Cross of Idaho endorses the conditions that CMS specifies in proposed 42 C.F.R. § 422.60(g)(2) that a MA organization’s highly integrated D-SNP must satisfy for the MA organization to receive “passive enrollment” of full-benefit dual eligibles under proposed 42 C.F.R. § 422.60(g)(1)(iii). Those conditions address matters such as the required extent of Medicare-Medicaid benefits integration and quality performance, legal and operational capacity to accept new enrollments, and appropriate limits on D-SNP premiums and cost-sharing. *See* 82 *Fed. Reg.* at 56493 (proposing to codify 42 C.F.R. § 422.60(g)(2)). Together those conditions reflect important lessons from deployment of “passive enrollment” under CMS’s Medicare-Medicaid Financial Alignment Initiative and provide important beneficiary protections, necessitating that a MA organization demonstrate it is willing, able and suited to receive those “passive enrollments.”

Blue Cross of Idaho particularly supports the condition that would require a MA organization receiving “passive enrollment” of full-benefit dual eligibles into a highly integrated D-SNP under 42 C.F.R. § 422.60(g)(1)(iii) to have at least an overall 3-star rating for that D-SNP in the plan year prior to the plan year in which the “passive enrollments” take effect (or qualify as a “low enrollment contract” or “new MA plan” under existing MA program regulations). *See* 82 *Fed. Reg.* at 56493 (proposing to codify 42 C.F.R. § 422.60(g)(2)(iii)). Blue Cross of Idaho concurs that it serves beneficiary best interest to require, not only that the D-SNP into which full-benefit dual eligibles are “passively enrolled” be a FIDE SNP or other D-SNP recognized as highly integrated by CMS, but also that the highly integrated D-SNP “have demonstrated commitment to quality . . . by being rated as having average or above-average performance on the MA Stars Rating System.” 82 *Fed. Reg.* at 56370.

Blue Cross of Idaho recommends modifying one of the conditions to accommodate CMS giving itself regulatory permission to “passively enroll” full-benefit dual eligibles into highly integrated D-SNPs when a State Medicaid agency elects to exercise its federal regulatory permission to undertake “passive enrollment” of Medicaid participants who are full-benefit dual eligibles into a voluntary Medicaid managed care option underlying highly integrated D-SNPs in the State. The modification is to limit application of the condition regarding provider network and benefit similarity in proposed 42 C.F.R. § 422.60(g)(2)(ii) to full-benefit dual eligibles being “passively enrolled” by CMS from one highly integrated D-SNP into another highly integrated D-SNP because of involuntary disruption of coverage.

- v. CMS should not limit its exercise of “passive enrollment,” as proposed in the CY2019 Medicare Program NPRM and as recommended in this letter, to only those circumstances where total costs do not increase for the Medicare and Medicaid programs.

Blue Cross of Idaho discourages CMS from limiting its exercise of “passive enrollment” to enroll full-benefit dual eligibles into highly integrated D-SNPs “to those circumstances in which such exercise would not raise total cost to the Medicare and Medicaid programs.” *Id.* CMS identifies the very challenge to introducing such limit when it asks in the CY2019 Medicare Program NPRM “how to calculate the projected impact on Medicare and Medicaid costs from exercise of this authority.” *Id.*

Blue Cross of Idaho believes that the exercise of “passive enrollment,” as proposed by CMS in the CY2019 Medicare Program NPRM and as recommended by Blue Cross of Idaho in this letter, is apt over time to have a positive cost impact on the Medicare and Medicaid programs. The reason is that, over time, the benefit of improved care quality, beneficiary satisfaction and care coordination and reduced administrative burden for

full-benefit dual eligibles will generate redounding financial and other benefits to the Medicare and Medicaid programs.

- vi. CMS should adopt its proposed single “passive enrollment” notice requirement for MA organizations receiving “passive enrollments” and leave to those MA organizations’ determination of additional “passive enrollment” notices to the full-benefit dual eligibles being “passively enrolled” into their highly integrated D-SNPs.

Blue Cross of Idaho supports a CMS mandate that MA organizations receiving “passive enrollment” of full-benefit dual eligibles into their highly integrated D-SNPs under “passive enrollment” need give only one notice of “passive enrollment” to the full-benefit dual eligibles being “passively enrolled.” See 82 *Fed. Reg.* at 56493 (proposing to codify 42 C.F.R. § 422.60(g)(2)(4)). By mandating a single “passive enrollment” notice, CMS permits MA organizations to assess the pros and cons of giving additional “passive enrollment” notices to those full-benefit dual eligibles and the appropriate content and timing for any such additional notices. MA organizations receiving “passive enrollments” may thus take into account State Medicaid agency and dual eligible input, cost, confusion risk, and other pertinent factors in making their determination of the advisability of giving additional “passive enrollment” notices to full-benefit dual eligibles being “passively enrolled.”

b. Recommended Revisions to Proposed 42 C.F.R. § 422.60(g)

Blue Cross of Idaho recommends the following revisions to clarify that the text of proposed 42 C.F.R. § 422.60(g) permits CMS to “passively enroll” full-benefit dual eligibles into highly integrated D-SNPs, including FIDE SNPs, when the full-benefit dual eligible’s existing coverage under a highly integrated D-SNP is involuntarily disrupted *and* when a State Medicaid agency elects to exercise its federal regulatory permission to undertake “passive enrollment” of full-benefit dual eligibles into a voluntary Medicaid managed care option underlying highly integrated D-SNPs in the State, subject in both cases to the receiving MA organization satisfying specified conditions for receiving those “passive enrollments.” The double-underlined text reflects proposed additions, and the double-strikethrough text reflects proposed deletions.

*“(g) Passive enrollment by CMS—(1) Circumstances in which CMS may implement passive enrollment. CMS may implement passive enrollment procedures in any of the following situations:*

*“(i) Immediate terminations as provided in § 422.510(b)(2)(i)(B).*

“(ii) CMS determines that remaining enrolled in a MA plan poses potential harm to the ~~members~~ MA plan enrollees.

“(iii) CMS determines, after consulting with the State Medicaid agency that contracts with the dual eligible special needs plan described in paragraph (g)(2)(i) of this section ~~and~~ that meets the requirements of paragraph (g)(2) of this section, that the passive enrollment will promote integrated care and continuity of care for a full-benefit dual eligible individual beneficiary (as defined in § 423.772 of this chapter and entitled to Medicare Part A and enrolled in Part B under title XVIII of the Act) who is currently enrolled in an integrated dual eligible special needs plan or who resides in a State in which the State Medicaid agency elects to undertake passive enrollment of individuals eligible for medical assistance for full-benefits under title XIX of the Act as authorized under § 438.54(c) of this chapter.

“(2) *MA plans that may receive passive enrollments.* CMS may implement passive enrollment, as described in paragraph (g)(1)(iii) of this section, only into MA ~~PD~~ plans that meet all the following requirements:

“(i) Operate as a fully integrated dual eligible special needs plan as defined in § 422.2, or a ~~specialized MA plan for dual eligible special needs plan individuals~~ that meets a high standard of integration, as described in § 422.102(e);~~≠~~

“(ii) Have substantially similar provider and facility networks and Medicare- and Medicaid-covered benefits as ~~the any~~ plan (or plans) from which the beneficiaries ~~are~~ may be passively enrolled into the receiving MA plan;~~≠~~

“(iii) Have an overall quality rating of at least 3 stars under the rating system described in § 422.160 through § 422.166 for the year prior to the plan year passive enrollments take effect or is a low enrollment contract or new MA plan as defined in § 422.252;~~≠~~

“(iv) Not have any prohibition on new enrollment imposed by CMS;~~≠~~

“(v) Have limits on premiums and cost-sharing appropriate to full-benefit dual eligible individuals beneficiaries; and

“(vi) Have the operational capacity to passively enroll full-benefit dual eligible individuals ~~beneficiaries~~ and agree to receive the passive enrollments.

“(3) *Passive enrollment procedures.* Individuals will be considered to have elected the MA plan selected by CMS unless they—

“(i) Decline the plan selected by CMS, in a form and manner determined by CMS, or

“(ii) Request enrollment in another plan.

“(4) *Beneficiary notification.* The MA organization that receives the passive enrollment must provide to the individual enrollee a notice that describes the costs and benefits of ~~the plan~~ and the process for accessing care under the MA plan and clearly explains the ~~beneficiary individual’s~~ ability to decline the enrollment or choose another plan. Such notice must be provided to all potential passively enrolled ~~enrollee individuals~~ prior to the enrollment effective date (or as soon as possible after the effective date if prior notice is not practical), in a form and manner determined by CMS.

“(5) *Special election period.* Individuals not otherwise eligible for a special election period at the time of passive enrollment will be provided with a special election period, in accordance with § 422.62(b)(4).” *Compare 82 Fed. Reg.* at 56493 (proposing to codify 42 C.F.R. § 422.60(g)).

Respectfully submitted,

Blue Cross of Idaho Health Service, Inc., and  
Blue Cross of Idaho Care Plus, Inc.

By:



Their: Executive VP, Consumer Healthcare