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Seema Verma

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

RE: CMS-4182-P.

Submitted electronically: <http://www.regulations.gov>

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California

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Claudia Schlosberg
Washington, DC

Dear Administrator Verma:

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am writing in response to the notice of proposed rulemaking issued by the Centers for Medicare & Medicaid Services (CMS) at 82 FR 56336 on November 28, 2017. NASUAD represents the 56 officially designated state and territorial agencies on aging and disabilities. Each of our members oversees the implementation of the Older Americans Act (OAA), and many also serve as the operating agency in their state for Medicaid waivers and managed long-term services and supports programs that serve older adults and individuals with disabilities. Together with our members, we work to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability and for their caregivers.

We are writing in response to several issues that directly impact our states' managed care plans. Specifically, we write to express our support for proposals that create simplified enrollment in integrated plans. Many of our states have reported challenges with aligning enrollment, eligibility, and services as well as with attracting sufficient plans who are willing to serve as the integrated care entity.

As part of this simplification, we are supportive of the proposed policy at 42 CFR 422.60 that would allow for passive enrollment of individuals in order to preserve continuity of care. We agree with CMS' assertion that such passive enrollment should only occur in consultation with state Medicaid agencies when the action is necessary to preserve continuity of care. As part of this passive enrollment, we strongly encourage CMS to ensure that the following considerations are taken into account:

- Smart enrollment algorithms are used to evaluate the continuity of care for the individuals to ensure that enrollment in the new plan does not result in disruption of prescription drugs included in the formulary and that the participant's existing providers are included in-network;
- Passive enrollment includes a mechanism for transferring existing care plans and authorized services, including mandated continuity of care provisions that require the new plan to adhere to an approved service plan for a minimum period of time;

- Robust and timely notification should be provided to participants to ensure that they have knowledge and understanding of the change and any implications on their overall services; and
- Alignment of the opt-out period for this passive enrollment proposal with the 90-day requirement included for individuals who are enrolled in Medicaid managed care plans.¹

We are also supportive of the proposal to codify current ‘seamless conversion’ policy (discussed in the rule as default enrollment in 42 CFR 422.66(c)(2)). As noted earlier, states struggle to build an integrated program for their newly dual-eligible members. When individuals move from a managed Medicaid program prior to attaining Medicare eligibility to an unmanaged Medicare benefit, it inhibits the ability of state Medicaid programs to provide ‘whole person’ care. Many states with Medicaid managed care programs are using the mandatory MIPPA contracts to drive integration; permitting the conversion of current Medicaid plan enrollees into an affiliated D-SNP will better serve the cause of integrated care.

Finally, we have concerns about overly restricting the Special Enrollment Period for individuals eligible for the Medicare Part D Low Income Subsidy (LIS), including those participants who are dually eligible for Medicare and Medicaid as proposed in 42 CFR 423.38. While we recognize that some participants frequently switch their plans, our experience indicates that this is an extremely small segment of the overall enrollment. Given the significant health and economic challenges that beneficiaries with LIS status experience, we do not believe it is prudent to limit plan changes to only once per year. The alternative approach outlined on p. 56375 – limiting switches to three times per year – may be a reasonable alternative. We caveat support of this approach by noting that there are other extenuating circumstances that may result in these participants needing to switch their plans for reasons but would not necessarily result in a new special enrollment period, such as a change in enrolled providers or a shift in the situation of the individual’s caregiver. We urge the Department to include these circumstances as disenrollment reasons, much like Medicaid permits disenrollment from a health plan for cause.

In any case, we recommend that CMS focus on providing strong options counseling to individuals in order to facilitate optimal plan selection during the initial open enrollment period, which we believe would reduce the need to switch plans at a later date.

If you have any questions regarding this letter, please feel free to contact Damon Terzaghi of my staff at dterzaghi@nasuad.org or (202) 898-2578.

Sincerely,



Martha A. Roherty
Executive Director

¹ See 42 CFR 438.56