



January 16, 2018

Mr. Demetrios Kouzoukas
Director, Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Director Kouzoukas,

On behalf of the nation's Medicaid Directors, we appreciate the opportunity to comment on Contract Year 2019 Policy and Technical Changes to the Medicare Program [CMS-4182-P]. The comments we offer focus specifically on proposed changes to enrollment policies regarding Medicare Advantage Duals Special Needs Plans (D-SNPs).

The National Association of Medicaid Directors (NAMD) is a bipartisan, nonprofit, professional organization representing leaders of state Medicaid agencies across the country. Our members drive major innovations in health care while overseeing Medicaid, which provides a vital health care safety net for more than 72 million Americans. In FY 2013, nearly 11 million of these beneficiaries were dually eligible for Medicare and Medicaid.¹

Dually eligible Medicare-Medicaid beneficiaries are one of the most complex and fragile populations in the nation, with significant care needs. Unfortunately, for many of these beneficiaries, a lack of integration of care across the two programs poses challenges for ensuring positive health outcomes delivered in a fiscally responsible manner. States, in partnership with the federal government, have pursued several integration approaches to ameliorate these issues, including but not limited to Financial Alignment Initiatives (FAI) demonstrations from the Center for Medicare and Medicaid Innovation, integrated D-SNP managed care programs through Medicare Advantage, and Programs of All-Inclusive Care for the Elderly (PACE).

¹ Medicaid and CHIP Payment and Access Commission. "MACStats: Medicaid and CHIP Data Book." Exhibit 14a, p. 39. <https://www.macpac.gov/publication/medicaid-enrollment-by-state-eligibility-group-and-dually-eligible-status/>

The D-SNP integration platform is particularly useful for states who are already delivering Medicaid services via managed care. However, certain barriers to effective transitions from Medicaid managed care products into integrated D-SNP products for Medicaid beneficiaries becoming eligible for Medicare currently impede maximizing the potential gains of the D-SNP model. Specifically, the moratorium on “seamless conversion” or “default enrollment” – a process which allows a beneficiary enrolled in a managed care plan to be enrolled in a Medicare Advantage plan offered by the same carrier – adversely impacts states’ abilities to leverage D-SNPs as an integration option. Only two states, Arizona and Tennessee, are currently able to utilize this authority.

A targeted lifting of the seamless conversion moratorium for Medicaid beneficiaries gaining Medicare eligibility is a key priority for Medicaid Directors. We are pleased that CMS is considering addressing this issue, and offer comments on specific provisions of the proposed rule below.

Default Enrollment Option for Medicaid Beneficiaries Becoming Medicare-Eligible

CMS proposes to revise §422.266 to allow default enrollment from a Medicaid managed care plan into a D-SNP for initial coverage election periods, provided that certain requirements are met. These requirements include both plans being offered by the same carrier, the state approving of default enrollment options both via contracting with the D-SNP and with the Medicare beneficiary identifying information shared to facilitate the enrollment, appropriate notices to the beneficiary being enrolled, and CMS approval of the default enrollment option for the Medicare Advantage organization.

NAMD is broadly supportive of these proposals and the role CMS envisions for states in the D-SNP default enrollment process. The proposed targeted application of default enrollment authority for Medicaid managed care-to-D-SNP enrollment is appropriate, given the unique nature of the dually eligible population compared to the broader Medicare Advantage population. The duals population has unique care needs and is best situated to benefit from the specialized provider networks, benefit packages, and care coordination functions offered by D-SNPs. Default enrollment authority may also enhance dually eligible beneficiary awareness of the D-SNP option.

Further, data from the two states currently able to utilize this authority shows that, with proper contracting safeguards and state oversight, the default enrollment process is a valuable tool for maintaining access to familiar providers and promoting continuity of care for the complex and fragile dually eligible population. In Tennessee, 95% of beneficiaries enrolled via seamless conversion were able to keep the same primary care provider at the end of the state’s 30-day

continuity of care period. D-SNP retention of beneficiaries enrolled via default enrollment in these states is high from year to year, with very low opt-out rates in the initial coverage period.

As an illustrative case, data from Arizona's seamless conversion program shows that, from August 2016 through June 2017, of the 4,427 members enrolled via seamless conversion:

- Only 270 (6%) opted out in advance;
- Only 93 (2%) disenrolled in the first 30 days;
- Only 133 (3%) disenrolled in the first 31 – 90 days; and
- The state received only two complaints regarding the seamless conversion process.

Data from Tennessee paints a similar picture. Of the nearly 5,300 members notified by a health plan of their pending enrollment into the plan's D-SNP, less than 5% opted out prior to the effective date of enrollment. One of the health plans had an opt-out rate of less than 1%; another had an opt-out rate of 1.5%. Rapid cycle disenrollments (occurring in the first 90 days following seamless conversion) were also low across all plans, with advance opt-outs and disenrollments within 90 days of enrollment each below 5%. Like Arizona, Tennessee received only two complaints regarding the seamless conversion enrollment process.

Health outcomes for these populations also show positive signs, suggesting the overall viability of D-SNPs as an integration strategy. This information strongly suggests that the expansion of default enrollment authority to all Medicaid programs would produce similarly positive results.

CMS specifically seeks comment on whether its approval of default enrollment authority for Medicare Advantage organizations should be time-limited, in order to provide more frequent opportunities to ensure regulatory requirements are being followed. NAMD supports CMS reviewing its approval decisions only when the state or CMS has reason to believe disruptions in beneficiary care are occurring. This approach would promote durability and permanency of default enrollment arrangements, which in turn supports overall integration strategies through the D-SNP vehicle. Alternatively, CMS may conduct a review of regulatory compliance within a certain time period (2 – 3 years), and grant permanent default enrollment authority upon satisfactory findings in that review.

Passive Enrollment Flexibilities to Promote Continuity of Integrated Care for Duals

CMS proposes to revise §422.60(G) to allow passive enrollment from one Fully Integrated Dual Eligible (FIDE) SNP or highly integrated D-SNP into another FIDE SNP or highly integrated D-SNP, under targeted circumstances. Specifically, CMS envisions utilizing its proposed passive enrollment authority only to preserve enrollment in integrated care plans when this enrollment status may otherwise be involuntarily disrupted – such as a D-SNP not renewing its Medicare

Advantage contract or not being selected under a Medicaid managed care competitive procurement process.

CMS envisions using this passive enrollment authority in consultation with the state, and that the D-SNP receiving passive enrollment must have a contract with the state. NAMD supports this approach, as state engagement is critical to ensuring passive enrollment authority is properly utilized. Any decision to passively enroll dually eligible beneficiaries from one D-SNP to another must reflect overall state integration goals and priorities, and be sensitive to any considerations or concerns the state may have for selecting one plan over another.

Additionally, CMS should explore how continuity of integrated care can be maintained in scenarios where states may have limited D-SNP penetration in their Medicare Advantage markets, and how disruptions to existing D-SNP presences can be accounted for. For example, some states have only a single FIDE SNP, and may not be able to avail themselves of the flexibilities envisioned in this passive enrollment approach.

Limitations on Special Enrollment Periods for Duals

Continuity of enrollment is a key element for stable managed care programs, regardless of the context in which they operate. For a population as specialized as duals, enrollment issues become critical, as states and plans must coordinate investments in care coordination, case management, and other supportive services that less medically complex populations may not require. At the same time, the complexity of the duals population requires appropriate safeguards to ensure beneficiaries are receiving the appropriate care in appropriate delivery constructs.

CMS acknowledges in the NPRM the challenges posed by current regulatory constructs for duals in the Medicare Part D prescription drug benefit, which allows a continuous Special Enrollment Period (SEP) to select a different Part D plan, including a Medicare Advantage Part D (MA-PD) plan. To promote stability for state and plan investments in this population, CMS proposes altering the current continuous SEP to a more limited universe of circumstances for SEPs, including a onetime, non-specific SEP each year, an SEP upon being assigned a plan by CMS or a state, and an SEP for changes in Medicaid or Medicare low-income subsidy eligibility status. All other SEPs that apply to the Medicare Advantage population writ large would also be available.

We acknowledge that these changes would significantly address potential churn between Medicare Advantage plans that could inhibit effective integrated care delivery for duals. However, some states have found that longer SEPs are a useful tool for promoting enrollment in



D-SNPs, as they allow more time to dedicate to beneficiary outreach and education regarding the advantages of an integrated plan.

Striking a balance between the objectives of stable enrollment and sufficient state flexibility to pursue effective integrated plan enrollment strategies is critical to improving care for duals. To achieve this balance, NAMD recommends CMS consider the following modifications to the NPRM proposals:

- An adjustment of the proposed 2-month SEP for changes in Medicaid or Medicare LIS eligibility status into a 3-month SEP. This additional time will allow appropriate beneficiary education on integrated care options through the enrollment process, which can be lengthy.
- Adoption of a continuous SEP exclusively for enrollment in a FIDE SNP or a comparably integrated plan, while disallowing selection of a non-integrated plan. CMS specifically sought comment on this approach, and it would be an effective means of balancing stable enrollment periods with appropriate beneficiary choice.
 - NAMD strongly recommends CMS consult with the state in defining "comparably integrated plan." Several states have D-SNPs which serve their integration strategies, but do not qualify for FIDE SNP status. States must have the opportunity to demonstrate that their D-SNP contracts and requirements support the goals of integration in circumstances where those approaches do not meet the at-times restrictive definition of a FIDE SNP.

Thank you for the opportunity to provide the perspectives of Medicaid Directors on these key elements of integration for duals. NAMD is ready to provide additional information on any of the points raised here, and look forward to continuing our partnership with CMS to improve care for this vulnerable population.

Sincerely,

A handwritten signature in blue ink that reads "Judy Mohr Peterson".

Judy Mohr Peterson
Med-QUEST Division Administrator
State of Hawaii
President, NAMD

A handwritten signature in black ink that reads "Kate McEvoy".

Kate McEvoy
State Medicaid Director
State of Connecticut
Vice President, NAMD