January 16, 2018

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

Dear Administrator Verma:

The SCAN Foundation (Foundation) welcomes the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) request for comment on the proposed rule for the *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* (CMS-4182-P). Many of the proposed changes work to provide increased flexibility to the health plans to offer more tailored products. However, without effective tools to help individuals understand the trade-offs between the different products, the benefits to individuals and the health system will not be realized. The current infrastructure does not support the transparent communication, implementation, and oversight of such flexibilities. The following comments begin to address these concerns to ensure beneficiary protections and high quality care, specifically focusing on people dually eligible for Medicare and Medicaid.

Provide clear guidance to Medicare Advantage plans on the scope and minimum requirements of person-centered care (p. 56375). The proposed rules include an expressed commitment to person-centered care in accordance with the CMS Quality Strategy. The CMS Quality Strategy includes multiple references to person-centered care, but does not clearly identify a common framework. Systems that incorporate person-centered care characteristics address what matters most to individuals receiving services, such as balancing complex care needs with individual daily living goals. In 2016, the Journal of the American Geriatric Society published a definition of person-centered care along with eight key characteristics. Additionally, four Essential Attributes, identified by an expert working group, provide a framework of a high-quality system of care for adults with complex care needs that operationalize person-centered care. CMS should use the these resources to develop clear federal criteria on the scope and minimum requirements of person-centered care as further guidance to Medicare Advantage (MA) organizations, allowing flexibility on how the criteria are met.

Ensure informed choice by further developing decision-making tools that provide transparent, easily understood information. CMS repeatedly mentions the Plan Finder tool on Medicare.gov as the source for accurate and transparent information for people selecting a Medicare plan. While the tool begins to provide insight into the available plans, it does not clearly communicate key differences between the plan offerings. Navigating systems of care is incredibly complicated, especially for people with complex care needs and those dually eligible for Medicare and Medicaid. The proposed rule includes several changes that would provide increased flexibility for MA organizations that could allow for variations in benefits packages and cost sharing that addresses the needs of target populations, but would add additional complexity to the decision-making process for individuals selecting a plan.

1. Uniformity Requirements (p. 56360) –MA organizations would be permitted to reduce cost sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria, provided that all who meet criteria are treated the same.
2. Segment (county-level) benefit variation (p. 56361) – MA organizations are currently able to offer plans with different premiums and cost sharing. The proposed rule would allow segments to vary by benefits as well.
3. Meaningful differences (p. 56363-56365) – The proposed rule would eliminate meaningful difference requirement allowing MA organizations to have multiple contracts in the same area that could be more tailored to enrollees' individual needs and financial situation.

In order to better support informed decision-making, people must have access to transparent, accurate and easily-understood information provided through culturally competent messaging. This became very apparent throughout implementation of California's financial alignment demonstration, Cal MediConnect. Key findings from a beneficiary survey found that people were more likely to decline participation in the demonstration when they did not clearly understand their choices and the benefits.

In reality, there is no organized source of information for dually eligible individuals to learn about health coverage options that integrate Medicare and Medicaid benefits. In a 2017 report, Integrated Care: What Options Exist for Californians with Medicare and Medi-Cal?, the Foundation began to identify the different types of integrated care models available in California. For people to make informed decisions they need easily accessible information to search for models of care and providers that best align with their needs and values. More research is needed to better understand what matters most to people when selecting a health plan or provider, and how best to develop a tool to assist in the decision-making process, especially as CMS provides MA organizations more flexibility to develop variation across plans.

Limit default enrollment to integrated models of care with strong oversight (p. 56366-56368). Default enrollment of newly Medicare eligible from Medicaid plans into a D-SNP within the same parent organization could help facilitate continuity of care and improve chances for care coordination. For these reasons, we recommend default enrollment only for D-SNPs and FIDE SNPs, and financial alignment demonstrations (if continued after the demonstration phase) with a star rating of 3 or greater. Proper oversight is important to ensuring the plans allowed to participate in default enrollment continue to provide high quality care. One of the options put forth in the proposed rules includes

establishing a set limit (i.e., 2-5 years) for a plan to be authorized for default enrollment. This would ensure that CMS regularly assesses quality and adherence to the default enrollment standards. We recommend CMS provide standard oversight by establishing a reauthorization process after a specified time frame for default enrollment.

Ensure access to quality care when implementing passive enrollment into integrated care models (p. 56369-56370). Dual eligible individuals often are not aware of the integrated care options available to them in their communities. Expansion of the regulatory authority for passive enrollment to ensure continuity of integrated care from one integrated care plan no longer available to another integrated care plan reinforces the value of integrated care and could mitigate the complexities connected to coverage decisions. Only high quality plans should be able to accept passive enrollment. One option to address quality would be to require plans to have NCQA performance-based accreditation. Most states require or recognize NCQA accreditation for their Medicaid plans. NCQA also has the only program accrediting plans providing long-term services and supports (LTSS), which some states require in Medicare-Medicaid Financial Alignment demonstrations. Features of NCQA's Medicaid Accreditation program provide the detailed assessment of quality needed for determining which plans should qualify for passive enrollments. We recommend CMS require integrated care plans have NCQA Medicaid plan accreditation and LTSS accreditation.

Provide clear and complete information about benefits, in-network physicians, and any continuity of care provisions when notifying individuals of passive enrollment into an integrated care plan (p. 56369-56370). While considering the number of notifications required for passive enrollment, CMS should also address content requirements. California implemented passive enrollment for Cal MediConnect, California's financial alignment demonstration, resulting in key learning about usefulness of notifications for passive enrollment. Evaluation results suggest that the perceived usefulness of the notification letters was likely an important driver of enrollment choices. While early notification letters let beneficiaries know they could opt out, beneficiaries reported the letters did not explain some key aspects of the program. When asked in a survey how the letters could be improved, beneficiaries said the letters should 1) describe changes in benefits; 2) needed to be written in a way that everyone could understand; and 3) include resources and simple tools that will tell them whether their providers are in-network. We recommend CMS draw from these findings to help shape useful notifications to individuals who are eligible for passive enrollment into integrated care plans.

Thank you for the opportunity to review and comment on the proposed rules.

Sincerely,

Bruce A. Chernof, M.D.
President and CEO