Ohio | Department of Medicaid

John R. Kasich, Governor
Barbara R. Sears, Director

January 17, 2018

Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: 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)

To Whom It May Concern:

Please accept the enclosed document as formal comment on behalf of the Ohio Department of Medicaid (ODM) regarding the Center for Medicare and Medicaid Services' recent Medicare program Notice of Proposed Rule Making.

ODM staff has thoroughly reviewed the proposed changes to federal rule regulating the Medicare program. Throughout our review process, we remained mindful of how the proposed changes may impact our state's Medicare population, as well as our ability to effectively manage several aspects of the program itself.

ODM agrees with several components of the proposed rule and supports many of the suggested updates including modifications to the special election period for dually eligible beneficiaries, limited expansion of passive enrollment authority, default enrollment into a D-SNP, initial coverage election period, and the drug utilization management program.

I ask that you consider our feedback and recommendations as work around prospective rule changes continue.

Sincerely,

Barbara R. Sears
Director

Enclosures

Delivery via e-mail

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January 5, 2018
CMS-4182-P

Comments on NPRM 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

Enrollment Periods (42 CFR §423.38)

Changes to the Special Election Period for dually eligible beneficiaries. To ensure that Part D sponsors are better able to administer benefits, including the coordination of Medicare and Medicaid benefits, CMS proposes to change the Special Election Period (SEP) for dually eligible and Low Income Subsidy (LIS) beneficiaries from an open-ended monthly SEP to: (1) one that would be limited to a certain period of time after a CMS or state-initiated enrollment; or (2) a one-time election to be used at any time in the year (unless the individual is identified as at-risk or potentially at-risk for prescription drug abuse under the CARA provisions described below)

ODM Response: Ohio supports the proposed amendment to 42 C.F.R. 423.38, which would hold dual and other LIS-eligible beneficiaries to election period requirements similar to those affecting all other Part D-eligible beneficiaries. The current regulations permit LIS beneficiaries to enroll and disenroll from prescription drug plans (PDPs) at any time interfering with care coordination efforts. Ohio is keenly aware of the negative consequences of an open-ended monthly SEP as a similar practice is allowed in our integrated care delivery system dual demonstration program, MyCare Ohio. Dual eligible individuals participating in MyCare Ohio are able to change plans monthly. Care coordination cannot be maximized when an individual is able to enroll in a different managed care plan each month.

Ohio also supports the proposed language that would place further restrictions on at-risk or potentially at-risk beneficiaries. As CMS notes, such beneficiaries may change drug plans in order to avoid drug management programs. A limitation on their SEP could be an important tool to improve care coordination and to help limit the beneficiaries' access to frequently abused drugs.

Election Process (42 CFR §422.60)

Limited expansion of passive enrollment authority. To promote integrated care and continuity of care, CMS proposes a limited expansion of current passive enrollment authority for full-benefit dually eligible beneficiaries from a non-renewing integrated D-SNP into another comparable D-SNP. This process would be conducted in consultation with the state Medicaid agency and where other conditions are met to ensure continuity and quality of care. Integrated D-SNPs would be defined as fully integrated D-SNPs (FIDE SNPs) or highly integrated D-SNPs

ODM Response: Ohio supports the proposal to expand passive enrollment authority to promote the continued enrollment of dually eligible beneficiaries into a D-SNP. A beneficiary who is currently enrolled in a D-SNP may be enrolled into a different D-SNP under certain circumstances. However, the proposed amendment to 42 C.F.R. 422.60 would limit the types of MA plans that could receive passive enrollments. The only plans that could receive such beneficiaries would be fully integrated dual eligible SNPs, as defined in 42 C.F.R. 422.2, or specialized MA plans that meet a high standard for integration, as described in 42 C.F.R. 422.102(e).

Ohio Medicaid does not contract with fully integrated dual eligible D-SNPs. Therefore, dually eligible beneficiaries in Ohio would not be afforded the benefits of the limited expansion of passive enrollment authority proposed by CMS. Ohio recommends this restriction be removed, expanding passive

enrollment authority to any D-SNP where the passive enrollment will promote integrated care and continuity of care for a full-benefit dually eligible beneficiary.

Coordination of enrollment and disenrollment through MA organizations (42 CFR §422.66)
Default enrollment into a D-SNP if individual is already enrolled in Medicaid MCO by the same company. CMS proposes to codify the current optional enrollment mechanism that provides seamless continuation of coverage by way of enrollment into an MA plan for newly MA-eligible individuals who are currently enrolled in other health plans offered by the MA organization (such as commercial or Medicaid plans) but with new limitations. Specifically, CMS proposes to limit default enrollments to D-SNPs that are enrolling newly Medicare-eligible individuals who are already, and will remain, enrolled in a Medicaid managed care plan operated by the same parent organization. The state must approve use of this default enrollment process and provide Medicare eligibility information to the MA organization offering the D-SNP.

ODM Response: Ohio Medicaid is supportive of the proposed regulation that would default an individual's enrollment into a D-SNP if the individual is already enrolled in the Medicaid MCO by the same company. Through our experience with the MyCare Ohio Demonstration Program, we have seen the benefits of care coordination when a single plan is coordinating both Medicaid and Medicare benefits. Medicare coverage directly impacts health outcomes and costs of Medicaid-covered services, but often the two benefits systems operate independently. A Medicaid managed care plan care manager is limited in helping a dual benefits member when they are unaware of the entire spectrum of care received. When a managed care plan provides both Medicare and Medicaid services, the care manager can effectively coordinate all of the member's care needs. By allowing seamless conversion into a D-SNP, dual eligible individuals can be afforded the benefits of maximum care coordination.

Effective dates of coverage and change of coverage (42 CFR §422.68)
Initial coverage election period. An election made prior to the month of Part A and Part B, it is effective as of the first day of the month to both Part A and Part B. If an election is made during or after the month to both Part A and Part B, it is effective the first day of the calendar month following the month in which the election is made. A change in election can be made during an open enrollment period. Annual 45-day period for disenrollment from MA plans to Original Medicare.

ODM Response: Ohio supports the clarifying amendments to 42 C.F.R. 422.68, which support the default enrollment process outlined in 42 C.F.R. 422.66.

Drug utilization management, quality assurance, and medication therapy management programs (42 CFR §423.153)
Drug management program for at-risk beneficiaries enrolled in their prescription drug benefit plans to address overutilization of frequently abused drugs. To combat the growing opioid epidemic, CMS proposes to implement new Comprehensive Addiction and Recovery Act of 2016 (CARA) requirements, including allowing plans to limit at-risk enrollees to use of selected providers and/or pharmacies, and limiting the availability of the SEP for dually eligible or other LIS-eligible beneficiaries who are identified as at-risk or potentially at-risk for prescription drug abuse under such a drug management program.

ODM Response: Ohio Medicaid supports the new proposed regulatory language concerning drug management programs for beneficiaries who are prescribed frequently abused drugs, but has highlighted a few concerns with the proposed policy below. For plan year 2019, CMS has proposed that opioids are frequently abused drugs. In light of the nationwide opioid epidemic, Ohio supports this designation of opioids as frequently abused drugs and agrees that the focus of drug management programs should be on controlling the inappropriate use and prescription of opioids.

The proposed rule changes will require a Part D sponsor to conduct case management for each potential at-risk beneficiary for the purpose of engaging in clinical contact with the prescribers of frequently abused drugs and verifying whether a beneficiary is at risk for prescription drug abuse. The Part D sponsor would be required to make reasonable attempts to reach the prescriber and determine whether the prescribed medications are appropriate for the beneficiary's medical condition. These efforts to contact the prescriber would be required before the beneficiary could be proposed for action that would limit access to these drugs through a "lock-in" program that would restrict the beneficiary to a particular prescriber or pharmacy, or subject the beneficiary to a point-of-sale claim edit. ODM agrees that this consultation with the prescriber should be required before a beneficiary's access to these drugs is restricted.

The Part D sponsor would also be required to seek the agreement of the prescriber that the beneficiary is suitable for lock-in. CMS has invited stakeholders to comment on not requiring prescriber agreement to implement pharmacy lock-in. While ODM generally supports this policy update, there is concern that the policy does not recognize potential quality of care issues that can exist with the prescriber which should then be handled through the plan's credentialing, program integrity, etc., processes. The plan should be given flexibility to consult with the patient's providers but it should not be limited to only the prescriber per se. It is important that the plan seek the prescriber's agreement to serve as the lock-in prescriber for the patient as well as the parameters of the program.

CMS observes that prescriber lock-in should be a tool of last resort to manage at-risk beneficiaries' access to coverage of frequently abused drugs. As a result, CMS proposes that a Part D sponsor may not limit an at-risk beneficiary's access to coverage of frequently-abused drugs to a selected prescriber(s) until at least 6 months have passed from the date the beneficiary is first identified as an at-risk beneficiary. The justification for the 6 month waiting period is to determine whether other case management interventions or limitations have resolved the beneficiary's overutilization of frequently abused drugs. CMS has invited comment on whether this 6 month waiting period is advisable, and whether any other operational considerations should be considered pertinent to this proposal. ODM is concerned with the 6 month waiting period for the patient especially if there's already been an established pattern of utilization. The 6 month waiting period could result in unintended harm or consequences for the member. Care management strategies could support the lock-in arrangement with the member.

The proposed rule amendments also address the termination of a beneficiary's potential at-risk or at-risk status. Specifically, CMS has proposed a maximum 12-month period for both a lock-in period and also for the duration of a beneficiary-specific point of sale claim edit for frequently abused drugs. This limit would not prevent an at-risk beneficiary from being subsequently identified as a potentially at-risk or at-risk beneficiary on the basis of new information on drug use occurring after the termination. ODM does not agree with mandating a 12 month maximum lock-in period. Our recommendation is that there be a continuous evaluation process that determinates the appropriate lock-in period for the individual given his/her plan of care and progress in meeting goals.