January 16, 2018

Centers for Medicare and Medicaid Services

United States Department of Health and Human Services

Attention: CMS-4182-P

PO Box 8013

Baltimore, Maryland 21244-8013

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

**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**

The Minnesota Department of Human Services appreciates the opportunity to comment on the proposed rule published in the Federal Register on Tuesday, November 28, 2017, Vol. 82, No. 227 at page 56336, also referred to as CMS-4182-P. We particularly welcome CMS’ recognition that state efforts to coordinate Medicare and Medicaid improves beneficiary experiences and quality of care for people who are eligible for both programs (“dual eligible people”).

Minnesota and CMS have successfully worked together for over 20 years to integrate Medicare and Medicaid into one seamless program for seniors in the statewide program known as Minnesota Senior Health Options (MSHO). This proposed rule contains important elements to advance that work, but other aspects of the proposed rule may have unintended consequences and need further refinement.

Thank you for lifting the seamless conversion moratorium for Medicaid beneficiaries, the proposed default seamless enrollment option and the proposed passive enrollment flexibilities. Despite these new options, Minnesota is concerned about negative effects of the proposed limitation for the Part D special election period (SEP) for dually eligible beneficiaries. Minnesota has not experienced the disruptions in enrollment that the elimination of the SEP is intended to guard against. We fear that limiting the Part D SEP will hamper Minnesota’s efforts to educate and enroll beneficiaries in Minnesota’s integrated Medicare and Medicaid programs, particularly beneficiaries who are members of cultural or ethnic minority communities.

One of the important administrative components of the MSHO program is that dually eligible members must enroll with the same health plan for both the Medicare and Medicaid managed care sides of the program, including Part D coverage, at the same time. Our system is designed so that disconnects cannot occur where a member might be enrolled in the health plan’s Medicare Advantage plan and not in its Medicaid health plan and vice versa. To assist in this effort, the state agency became the Third Party Administrator (TPA) for enrollment in the MSHO health plans and coordinates the Medicaid and Medicare enrollment files both for the MCOs and for submission to CMS.

As a TPA, Minnesota is familiar with the technical enrollment requirements and areas that have been troublesome for integration. Minnesota has relied heavily on the existing year-round continuous SEP to successfully enroll dual eligible people into integrated programs. Minnesota has also relied on the rough alignment between the Medicare and Medicaid annual enrollment time periods. Even with these existing tools, we have been unable to enroll many people who would otherwise be eligible for and benefit from enrollment in an integrated product. We recommend that CMS avoid adopting the proposed limitation on the Part D SEP. Alternatively, we recommend limiting the existing continuous SEP to duals enrolling into or choosing between products that are offered within programs developed especially for dual eligible people by states.

We are also concerned about the loss of the continuous SEP in conjunction with the change in the annual open enrollment period for Medicare to the first three months of the year. With this change, the dates will no longer align with the traditional end-of-year open enrollment for Medicaid in Minnesota. Minnesota’s managed care contracting cycle is tied to a calendar year and would be difficult to change. Minnesota has effectively utilized the overlapping Medicaid and Medicare open enrollment periods (as well as Medicare open enrollment election type code) to educate and enroll eligible beneficiaries into MSHO. Disparate annual enrollment periods will require additional explanations and mailings to dually eligible beneficiaries, thereby increasing confusion and decreasing enrollment in integrated programs. We urge CMS to develop an election type code that aligns with the state Medicaid annual enrollment period and to work with states to alleviate Medicaid compliance requirements that result in duplicate mailings to duals.

Finally, Minnesota supports quality improvement programs for Medicare Advantage organizations.

Below please find Minnesota’s detailed comments regarding particular sections of the notice of proposed rulemaking.

1. **Coordination of Enrollment and Disenrollment through MA Organizations and Effective Dates of Coverage and Change of Coverage, pp. 56365-56368; §§ 422.66 and 422.68**

We applaud the proposed changes to the seamless default enrollment process. As CMS has noted, there is growing evidence that integrated care and financing models can improve beneficiary experience and quality of care. Unfortunately, it is difficult to educate dual eligible people about the complexity of their health care choices upon becoming eligible for both Medicare and Medicaid. Under existing authorities, Minnesota Medicaid enrollees who become dually eligible are automatically enrolled into a Medicaid-only managed care product unless they make an active choice to enroll in an integrated product.

Minnesota has successfully worked with CMS to ensure our Medicaid enrollment form meets Medicare requirements for enrollment into Medicare Advantage. This avoids a transition where a recipient might enroll in Medicaid managed care and then have to choose a stand-alone Part D plan -- only to then later enroll in MSHO and have to transition their prescription drugs. The existing special enrollment period (SEP) for dual eligible members has allowed us to continuously enroll Medicaid recipients into MSHO at any time, not just when they first become Medicaid eligible. Minnesota has long noted that it is more difficult to encourage people to try an integrated Medicare-Medicaid product once a Part D plan has been selected for them.

This proposed set of changes have potential to make it significantly easier to allow Minnesota Medicaid enrollees converting to dual eligibility to experience the benefits of an integrated program in cases where their existing Medicaid managed care plan offers an integrated product in the same service area. We appreciate CMS efforts to support enrollment into plans that offer some level of integration of acute care, behavioral health and long-term care services and supports. We also appreciate the preservation of consumer choice under the proposed voluntary opt-out SEP.

Although we wholeheartedly support the concept, Minnesota requests that CMS further consider the operational difficulty of identifying beneficiaries 90 days in advance of Medicare eligibility. Our pastexperience with seamless enrollment teaches that in some instances it is difficult to identify beneficiaries becoming newly eligible for Medicare benefits ninety days in advance and to send the notice 60 days in advance to enroll beneficiaries on the first of the month they become Medicare eligible. If the timing of the notice was missed we were unable to enroll the beneficiary in the coordinating Medicare/Medicaid plan. Minnesota requests flexibility to send the notice up to three months beyond when the beneficiary first becomes Medicare eligible, and prospectively enroll based on when the notice is sent. This would allow the largest possible group of beneficiaries to benefit from the proposed expansion of seamless default enrollment. Finally, Minnesota respectfully notes that seamless default enrollment will not entirely alleviate the need for a continuous Part D SEP, because it is limited to situations in which a beneficiary is enrolled in Medicaid managed care plan that also offers an integrated product in the same service area. This is not achievable, especially for Medicare eligible enrollees who have spent down to Medicaid income levels.

**Recommendation:**

* **Minnesota supports the proposed limited authorization of default enrollment (previously called seamless conversion) from Medicaid plans into D-SNPs.**
* **Minnesota requests that further flexibility be granted to accommodate operational difficulties in prospectively identifying eligible beneficiaries, and to allow sending the notice up to 90 days past the first day of the month of initial Medicare eligibility in order to assist the largest number of beneficiaries to enroll in integrated programs like MSHO.**
* **Minnesota does not recommend time limits on approval of D-SNPs for default enrollment**

1. **Passive Enrollment Flexibilities to Protect Continuity of Integrated Care for Dually Eligible Beneficiaries pp 56369-56371; § 422.60(g)**

The proposed passive enrollment flexibilities will also be of value to promote integrated care and continuity of care for dual eligible people in situations where disruptions in coverage occur due to circumstances outside the control of beneficiaries. Minnesota particularly appreciates the attention to the need to partner with state Medicaid agencies in applying these flexibilities, as well as the preservation of consumer choice through the proposed voluntary opt-out SEP.

**Recommendation:**

* **Minnesota supports the proposed passive enrollment flexibilities.**
* **Minnesota recommends that achievement of a particular star rating is not a necessary qualification for a plan to participate in passive enrollment because that star ratings may be affected more by the percentage of duals enrolled in a plan than other factors, and that state approval should be required instead. This would give CMS and states flexibility to avoid enrollment into a particular plan if significant problems have been identified, but otherwise allow the largest number of dual eligible people to benefit from enrollment in an integrated program.**
* **Minnesota believes that current Medicare notice requirements are sufficient, and states may impose additional notice requirements upon D-SNPs if the state determines additional notice is prudent, or as requested by local stakeholders**

1. **Establishing Limitations for the Part D Special Election Period (SEP) for Dually Eligible Beneficiaries pp 56373-56375; 423.38**

Minnesota remains committed to our longstanding and successful Minnesota Senior Health Options (MSHO) program. We continue to seek out ways to improve the program and to promote Medicare and Medicaid integration for adults with disabilities. A key component of MSHO’s success has been twenty years of close attention to managing administrative details related to Medicare and Medicaid messaging and enrollment so that beneficiaries are able to interact with their health coverage as if it is one seamless program, despite the complexities of financing and coverage behind the scenes.

Minnesota has not experienced the churn in enrollment that is apparently fueling the CMS desire to limit the existing dual SEP. We support the goal to encourage duals to enroll in integrated programs. However, we fear that eliminating the continuous SEP may prevent duals from enrolling in integrated programs. We support the option to tailor the continuous SEP to allow it to be used to enroll into FIDE SNPS “or comparably integrated products,” as described on page 56375 of the Register as long as there is state input on what is a “comparably integrated product. ”

The current FIDE SNP definition is too narrow to encompass all worthwhile state integration efforts. For example, the Minnesota plans that serve our disabled duals have at times been denied FIDE SNP status because our the Medicaid program for adults with disabilities doesn’t include comprehensive long term care benefits in the managed care benefit set. The program design was in part based on input from stakeholders about the best models for dual eligible people under age 65.

The proposed seamless enrollment authorities will likely be very helpful for existing Medicaid enrollees converting to dual eligibility to experience the benefits of an integrated program in cases where their existing Medicaid managed care plan offers an integrated product in the same service area. In addition, the proposed passive enrollment authorities will support continuity of integrated coverage for duals who would otherwise need to take action due to a service area change. Between these two new authorities, many enrollment actions will now become easier for dual eligible people.

However, there are number of other situations in which duals may still need the existing Part D continuous SEP in order to enroll in an integrated product. For example, a person who is enrolled in Medicare and later becomes eligible for Medicaid (e.g., by spending down assets) would not be assisted by seamless enrollment. The limited exceptions at §423.38 do not fully mitigate these circumstances. Therefore, Minnesota strongly recommends that CMS continue the existing continuous Part D SEP. Alternatively, we recommend limiting the existing continuous SEP to duals enrolling into or choosing between products that are offered within programs developed especially for dual eligibles by states.

1. Special considerations relating to education of dual eligible people

First, any change in the dual SEP needs to recognize that it is difficult to educate dual eligible people about their choices, because this requires a thorough description of Original Medicare, Part D, Medicare Advantage, Medicaid and how the programs interact. Many dual eligible people are quite ill or elderly, and may be overwhelmed with socioeconomic challenges as well. Selecting the right health care program may be beneficial, but it is difficult to convince people to take action quickly with so many competing demands on their time. Focus groups conducted by Minnesota found that some duals in minority ethnic groups and their families are particularly suspicious of managed care and of promises that sound “too good to be true.” The knowledge that they can disenroll at any time is very comforting for those trying out an integrated product. With all the difficulty of educating people, it is even more confusing if, after all the educational efforts, an enrollment request is denied merely for timeliness. Time limitations on SEPs adds another layer of complexity to the challenge of enrolling dual eligible people in integrated programs.

Because of these realities, Minnesota is concerned by the proposed substitution of specific time-limited SEPs in place of the existing continuous SEP. Limitations on SEPs will be more difficult to convey adequately and will result in situations where consumers experience the loss of needed flexibility because a form is not submitted on time. These experiences can erode confidence in the integrated Medicare and Medicaid product, especially among tight-knit cultural communities where stories travel quickly.

1. Special considerations due to unique challenges for dual eligible people to retain managed care enrollment

Second, any change in the dual SEP must be sufficient to support the unique challenges experienced by dual eligible people that may require more changes in health plan enrollment than what is currently experienced by Medicare eligible people. For example, dual eligible people have unique enrollment challenges due to disruption in Medicaid eligibility and the sensitive nature of receiving some long term services provided within the Medicaid health plan network. As noted above, Minnesota strongly recommends that CMS continue the existing continuous Part D SEP. Alternatively, we recommend limiting the existing continuous SEP to duals enrolling into or choosing between products that are offered within programs developed especially for dual eligible people by states to allow duals to navigate these unique challenges. If CMS determines that neither of these recommendations are possible, Minnesota urges CMS to remove time limitations on the proposed specific SEPS where possible. In particular, the SEP related to “elections within 2 months of a gain, loss or change to Medicaid or LIS eligibility” at 423.38 (c) (9) is unworkable for dual eligible people in Minnesota.

Front-end Medicaid enrollment procedures may take too long for dual eligible people to make meaningful use of this SEP in many instances. It takes time to identify people with eligibility changes and mail the appropriate materials describing choice of health plans and programs. Beneficiaries and their families need sufficient time to consider their choices and submit the appropriate forms. By then, auto assignment by CMS into another Part D plan may have occurred, generating another two month option to enroll into an integrated product, another set of notice materials to confuse beneficiaries, and another deadline that may be missed. It is much better for beneficiaries to have a continuous SEP so that enrollment in an integrated product can occur promptly and simply when the beneficiary is ready.

In addition, there are many factors that result in a person repeatedly losing and regaining Medicaid eligibility. Loss of Medicaid eligibility can cause great disruption in a person’s life, making timely choice of health plan a lower priority. Some losses of Medicaid eligibility are short in duration and easily managed. Others are more protracted.

Under the current Chapter 2 §50.2.5 “Loss of Special Needs Status” the SNP can continue to provide care for up to six months when the beneficiary is expected to regain Medicaid eligibility. In Minnesota, the State requires (by contract and our state plan) the SNP to continue to provide care for up to three months when Medicaid eligibility is lost. When the beneficiary fails to regain Medicaid eligibility within those three months the beneficiary is dis-enrolled from the integrated health plan product (MSHO). If the beneficiary regains Medicaid eligibility after those three months they must complete a new enrollment application for prospective integrated enrollment in MSHO. The election type currently used for the enrollment is the Dual/SEP election type. Elimination of this election type could result in difficulties re-enrolling beneficiaries in the dual integrated product. Dual eligible people have an urgent need for a simple and effective way to reenroll in an integrated programs in the case of a loss or change to Medicaid eligibility. The current continuous Part D SEP has been effective and valuable for this purpose.

In addition to the unique difficulty of managing disruptions in Medicaid eligibility, Minnesota urges CMS to consider that dual eligible people have legitimate reasons to switch health plans within an integrated program. Medicaid programs may offer an array of long term services and supports to serve people who are at risk of institutionalization. Dual eligible people receiving these services must have a high level of trust with these providers to safely live in a community setting. Changes in Medicaid health plan provider networks for these services may have great impact on quality of life,-- so much so that the new Medicaid managed care regulations provide a special for-cause provision for disenrollment in these situations at 42 CFR 438.56(d)(2)(iv). The current rules have allowed Minnesota to disenroll beneficiaries who are unhappy with their choice of plan and choose to return to a Medicaid only product or a different integrated health plan. Minnesota’s MSHO program rules require that a beneficiary enroll with the same health plan for Medicaid and Medicare benefits. Loss of the continuous SEP could impede integration if members change their Medicaid plan but are not allowed to enroll in the companion Medicare integrated plan.

1. Interaction between the change in annual open enrollment dates and loss of the SEP

Third, the proposed changes in annual open enrollment time frames increase the need to retain the existing Part D SEP. The open enrollment period is proposed to change from late fall to the first three months of the year. This de-links the Medicare open enrollment period from Minnesota’s open enrollment period, which runs the last quarter of each year with an effective date of change the first of the calendar year. We have found this time period to be consistent with the majority of employer group policies, and with our other programs. The Medicare change in timeframe will create communication difficulties for beneficiaries, making it difficult for them to understand when their annual open enrollment period runs. Potentially, an enrollee could be faced with even more requests to complete forms to enroll in an integrated program. We suggest that CMS allow states with integrated MAO/Medicaid programs to retain their existing open enrollment period.

In summary, Minnesota does not support the proposed limitations for the Part D SEP for dually eligible beneficiaries proposed at 423.38 because the time limitations and restrictions to specific circumstances will be prohibitively difficult for dually eligible people to understand and use, and will not be available in many circumstances where consumer choice is in the best interest of the individual. The best case scenario for Minnesota would be to not implement the changes to the current continuous SEP for duals. Minnesota supports the alternative idea put forth at page 56375 to allow continuous use of the dual SEP to allow eligible beneficiaries to enroll into integrated products for dually eligible beneficiaries. This option needs to be further developed to clarify which integrated products are acceptable. We believe that this would meet the proposed goals of the regulation while at the same time preserving necessary enrollee choice.

As CMS continues its analysis, Minnesota asks that policy makers keep in mind the many enrollment situations confronting duals. Minnesota has found that to maintain a seamless integrated enrollment experience for beneficiaries interacting with two disparate federal programs requires attention to the following situations and life events, each of which comes with its own unique challenges:

* Choice of coverage for people who are existing Medicare beneficiaries and have incurred sufficient expenses to spend down to Medicaid income levels
* Choice of coverage for people who are existing Medicaid beneficiaries and have met Medicare enrollment
* Choice of coverage during and following disruptions of Medicaid eligibility (and therefore dual eligibility) due to periodic Medicaid eligibility redetermination requirements (Medicaid disruption)
* Choice of coverage at the annual Medicaid and Medicare open enrollment periods, which until now have been roughly aligned
* Choice of coverage for dual eligible people who have become educated about integrated Medicare and Medicaid options and wish to join a new managed care plan
* Choice of coverage for dual eligible people who move to a new state or a new service area within the state, often because of choosing a Medicaid residential service provider.
* Choice of coverage for dual eligible people who wish to change plans due to a change in health status and a desire for access to a particular providers or drugs or due to a change at the plan level relating to network, formulary or model of care.
* Choice of coverage for dual eligible people whose plan has left the service area
* Choice of coverage for dual eligible people at the point at which state program requirements require choice (i.e. turning 65 in states like Minnesota that provide different programs for seniors than for adults with disabilities under age 65)

Although Minnesota applauds the proposed seamless enrollment and passive enrollment flexibilities and appreciates the proposed flexibilities in the NPRM, we do not believe that the proposed specific and time-limited proposed SEPs will be sufficient to assist dual eligible people in maintaining enrollment in integrated programs and provide sufficient choice of plan within these programs for all of the above situations.

**Recommendations:**

* **Minnesota does not support eliminating the continuous SEP because this may prevent dual eligible people from enrolling in integrated programs.**
* **Minnesota supports the option to tailor the continuous SEP to allow it to be used to enroll into FIDE SNPS “or comparably integrated products,” as described on page 56375 of the Register as long as there is state input on what is a “comparably integrated product. ” The FIDE SNP definition is too narrow to encompass all worthwhile state integration efforts. For example, our plans who serve our disabled duals have been denied FIDE SNP status because, in deference to our stakeholders, the Medicaid program for adults with disabilities doesn’t include comprehensive long term care benefits in the managed care benefit set.**
* **If CMS determines that the continuous SEP will be eliminated and cannot be tailored as described above, Minnesota recommends that CMS lengthen or eliminate the two month time limitation at 42 CFR 438.56(d)(2)(iv). Minnesota also recommends that CMS develop a SEP to allow dual eligible people to disenroll or enroll in another Medicare plan in the case of disruption of provider networks for managed long term services and supports in a companion integrated Medicaid health plan.**

1. **Removal of Quality Improvement Project for Medicare Advantage Organizations, pp 56454-56455, § 422.152**

Minnesota is disappointed that CMS is proposed to remove the requirement for quality improvement projects. Although the usefulness of these activities has been mixed, the requirements for this activity dovetail with existing Medicaid quality requirements. Integrated programs have a unique opportunity to pursue joint Medicare and Medicaid quality improvement projects, and we fear that the lessening of CMS expectations in this area will result in less attention on such activities by D-SNPs.

**Recommendations:**

* **Minnesota does not support removal of quality improvement projects for Medicare Advantage Organizations**