**Ohio**

**Department of Medicaid**

**John R. Kaslch,** Governor

**Barbara R. Sears,** Director

January 17, 2018

Ce nt ers for M edicare and Medicaid Servi ces Department of Healt h and Human Services 200 Independence Avenue, SW

Washingt o n, 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

**(CM S-4182-P)**

To Whom It M ay Co ncern:

Please accept the enclosed doc ument as formal comm ent on behalf of the Ohio Dep artm ent of

M edicai d (ODM) regardin g t he Center for M edicare and M edicaid Services' recent M edicare program Not ice of Pro pose d Rul e Making.

ODM st aff has thoroughly reviewed the proposed changes to federal rule regulating t he Medicare program. Thro ughout our review process, we remain ed mindful of how the proposed changes m ay impact our st at e' s M edicare populat ion, as well as our ability to effectively manage several aspects of t he program it self .

ODM agrees with several components of t he pro posed rule and supports many of the suggested updat es includin g modificati ons to th e special election period for duall y eligible beneficiaries, limit ed expansi o n of p assiv e enrollm ent aut horit y, default enrollment into a D-SNP, init ial coverage elect ion period, and t he dru g ut ilizat ion management pro gram .

I ask th at you consid er our feedback and recommendati on s as work around pro spective rule changes continu e.

Sin cerely,

Director Encl os ur es

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**Comments on NPRM CM S-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 bet ter able to administer benefits, including the coordination of Medicare and Medicaid benefits, CMS propos es to change the Special Election Perio d (SEP) for dually eligible and Low Income Sub sid y (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 identi fied as at-risk or potentially at-risk for prescr iption drug abuse und er the CARA provisions described below)

**ODM Response :** Ohio support s th e proposed amendment to 42 C.F.R. 423. 38, which would hold dual and other LIS-eligible beneficiaries to election period requirements similar to t hose affecting all other Part D-eligible beneficiari es. The current regulations permit LIS beneficiarie s to enroll and disenroll from prescription drug plans (PDPs) at any time interfering with care coordination efforts. Ohio is keenly aware of the negativ e consequences of an open-ended monthly SEP as a similar practice is allowed in our integrated care delivery system dual demonstration program, MyCar e Ohio. Dual eligible individuals participating in MyCare Ohio are able to change plan s monthly. Care coordination cannot be maximi zed when an individual is able to enroll in a differ ent managed care plan each month.

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

**Election Process (42 CFR §422.60)**

*Lim ited expansion of passive enrollmen t authority.* To promote integrated care and continuity of care, CMS proposes a limited expansion of curr ent passive enrollment authority for full-benefit dually eligible beneficiari es from a non-r enewing integrated D-SNP into another comparable D-SNP. This proc ess would be conducted **in** consult ation with the stat e Medicaid agency and where other conditions are met to ensur e continuity and quality of care. Int egrated D-SNPs would be defi ned as fully integrated D-SNPs (FIDE SNPs) or hi ghl y integrated D-SNP s

**ODM Response:** Ohio support s th e proposal to expand passive enrollment authority to promote the continued enrollment of dually eligible beneficiaries into a D-SNP. A bene ficiary who is currently

enrolled in a D-SNP may be enrolled into a diff erent D-SNP und er 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 beneficiari es would be fully integrated dual eligible SNPs, as defined in 42 C.F.R. 422.2, or specializ ed MA plans that meet a high standard for integration, as described in 42 C.F. R. 4 22.102(e).

Ohio M edicaid does not contract with fully integrated dual eligible D-SNPs. Therefore, dually eligible beneficiarie s in Ohio would not be afford ed the benefit s of the limited expansion of passive enrollment authority proposed by CMS. Ohio recommends this rest rict ion be removed, expanding passive

enrollment aut horit y to any D-SNP where the passive enrollment will promote int egrated care and continuity of care for a full-benefit dually eligible beneficiary.

# Coordination of enrollment and disenrollment through MA organizations (42 CFR §422.66)

*De fault enrollment into a D-SNP if individual is already enr olled in Me dicaid MCO by th e same company.* CMS proposes to codify the curr ent optional enrollment mechani sm that provides seam less continuation of coverage by way of enrollment into an MA plan for newly M A-eligible individuals who are currently enro lled in other healt h plans off ered by the MA organization (su ch as commercial or

Medicaid plans) but with new limitat ions. Specifically , CMS proposes to limit default enrollments to D­ SNPs t h at are enrolling newly Medicare-eligible individual s who are already, and will rem ain, enrolled in a M edicaid m anaged care plan operated by the same parent organization. The stat e must appro ve use of this default enrollment process and provid e M edicare eligibility information to the MA organization offering the D-SNP.

**ODM Response:** Ohio Medicaid is supportiv e of the proposed regulation that would default an individual' s enrollment into a D-SNP if t h e individu al is already enrolled in the M edicaid MCO by the same company. Through our experience with the M yCare Ohio Demon st rat ion Program, we have seen t he benefits of care coordination when a sin gle plan is coordinating both Medicaid and M edicar e benefits. Medicare coverage directly impacts health outcomes and costs of Medicaid-cov ered services, but often the two benefits systems operate independent ly. A Medicaid managed care plan care

manager is limit ed in helping a dual benefits m e mb er when they are unaware of the entire spe ctrum of care received. When a managed care plan providesboth Medicare and Medicaid services, t he care

manager can effectiv ely coordinate all of the member' s care needs. By all owing seam less conversion into a D-SNP, dual eligible individuals can be afforded the benefit s 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 effect ive as of the fi rst d ay of the month to both Part A and Part B. If an elect ion is m ade during or after the month to both Part A and Part B, it is e ff ect ive the first day of the calendar month following the month in which the election is mad e. A change in elect ion can be made during an open enrollment period.

Annual 45-day period for disenrollment from MA plans to Origin al M edicare.

**ODM Response:** Ohio support s t he clarifyin g ame ndment s to 42 C.F.R. 4 22.68, 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 mana ge me nt program for at-risk beneficiaries enrolle d in their prescription drug benefit plans to*

*address overutilization of frequently abused drugs.* To combat the growing opioid epidemic, CMS

pro poses to im plement new Comprehensive Addiction and Recovery Act of 2016 (CARA) requirements, including allow ing plans to limit at -ri sk enr ollees to use of selected providers and/ or pharm acies, and limit ing the availability of the SEP for dually eligibl e or other LIS-eligible beneficiarie s who are identified as at -risk or potentially at-risk for prescript ion drug abuse und er such a dru g management program.

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**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 theprescriber 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.